Confidential Patient Health Record

DATE	I.D. NO.

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ State/Prov: _____ Zip/Postal Code: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: ☐ M ☐ F

Cell Phone: _____ E-mail Address: _____

Social Security # _____ Driver's License Number: _____

Social Insurance # _____ Circle One: Married Single Widowed Divorced Separated

Business Employer: _____ Type of Work: _____

Business Phone: _____ Spouse's Social Security # _____

Name of Spouse _____ Spouse's Social Insurance # _____

Spouse's Employer _____ Business Phone _____

Type of Work _____ Name and Ages of Children _____

Referred To This Office By: _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who Is Responsible For Your Bill, You and ☐ Spouse ☐ Workers' Comp. ☐ Auto Insurance ☐ Medicare ☐ Medicaid

☐ Personal Health Insurance (Name) _____ ☐ Health Card # _____

Insured Person's Name _____ Date of Birth _____

CURRENT HEALTH CONDITION

Unwanted Health Condition _____

Other Doctors Seen For This Condition: ☐ Yes ☐ No ____ Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? ☐ Yes ☐ No

Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____

Date of Accident: _____ Time of Accident: _____

Have You Made A Report of Your Accident To Your Employer: ☐ Yes ☐ No

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine

☐ Insulin ☐ Other _____

Do You Wear A Shoe Lift? ☐ Yes ☐ No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other _____

Major Accident or Falls: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit _____

Below are a list of diseases which seem unrelated to the purpose of your ntment. However, these questions must be answered carefully as these oblems can affect your overall course of .

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

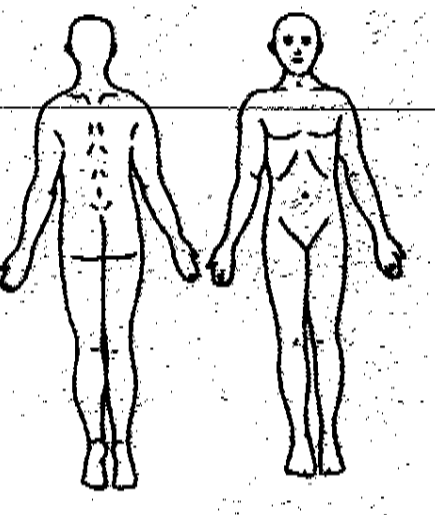
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

FEMALES ONLY:

When was your last period?_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

Doctor's Signature

HIPAA TODAY

Notice of Privacy Practices

HIPAA, the Health Insurance Portability and Accountability Act of 1996 has recently been formalized and will help govern the relationship between patients and their providers of healthcare to provide all entitled medical services in the most efficient way.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU, AS THE PATIENT, MAY GET ACCESS TO THIS INFORMATION.

We appreciate the trust that patients place in us and we recognize the importance of protecting the confidentiality of non-public personal information that we have in our possession. This information will be used only to ensure accuracy in carrying out treatments for you and in keeping your records. In conducting transactions with patient's health carriers or affiliates they designate, we will always endeavor to use information that is absolutely necessary to comply. If we change this policy, we will notify you in advance.

This notice describes the information privacy practices that are followed in the **OLDE TOWNE WELLNESS, LLC.**

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status and the health care services you receive at this office. It also reviews the ways in which your health information may be disclosed to other entities and it describes your rights and our obligations in managing the privacy and integrity of your care. We are required by law to give you this notice and to help you understand its intent. You must signify your understanding and agreement by signing in the appropriate space below. You may opt out of this agreement at any time by presenting our office with written notice of your wishes.

Patient or Guardian Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

Witness: _____ Date: _____

OLDE TOWNE WILLNESS, 515 S. SYCAMORE ST., PETERSBURG, VA 23803

FINANCIAL POLICY AND INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard or Visa. We will be happy to process your insurance claim-form and we accept assignment of insurance benefits. You are responsible for annual deductibles and any amount not covered by your insurance.

Returned checks and balances older than 30 days may be subject to additional collection fees. You would also be responsible for any legal fees, court, or collection agency costs incurred, which are necessary to enforce this agreement. Those additional expenses for legal or collection agency fees or court costs, will be added on top of this billing and/or fees with the interest rate of 1 ½% per month, calculated from the date chiropractic services were first rendered. Charges may also be made for broken appointments and appointments canceled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50%, or 80%) or "U.C.R." ("U.C.R." is defined as usual, customary and reasonable by most companies.

   This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as health care providers, **our relationship is with you, not your insurance company**. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read and understand the financial policy of Olde Towne Wellness.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

Olde Towne Wellness LLC
Dr. Thomas Hennessey

Consent for Purposes of Treatment, Payment and Healthcare Operations

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Olde Towne Wellness LLC for the purpose of +diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Olde Towne Wellness LLC. I understand that Dr. Hennessey may refuse to diagnose or treatment me, if I do not consent to the use or disclose of my protected health information for the above stated purposes. (My signature on this document is evidence of this consent.)

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Olde Towne Wellness LLC is not required to agree to the restrictions that I may request. However, If Olde Towne Wellness LLC agrees to a restriction that I request, the restriction is binding on Olde Towne Wellness LLC and Dr. Hennessey.

I understand I have a right to review Olde Towne Wellness LLC's Notice of Privacy Practices prior to signing this document. Olde Towne Wellness LLC's Notice of Privacy Practices has been provided for me. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Olde Towne Wellness LLC. The Notice of Privacy Practices for Olde Towne Wellness LLC is also provided on request at the main administrative desk of this practice. Notice of Privacy Practices also describes my rights and Olde Towne Wellness LLC's duties with respect to my protected health information.

Olde Towne Wellness LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling Olde Towne Wellness LLC's office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, at any time, except to the extent that Olde Towne Wellness LLC or Dr. Hennessey has taken action in reliance on this consent.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority