Confidential Patient Case History

Your Personal Information

Your Name _____ Referred By _____

E Mail _____ Today's Date _____ Birth Date _____

Mailing Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____ SS # _____

Your Age _____ When and where was your last Chiropractic visit? _____ Number of children ___

Employer _____ Occupation _____ Spouse's Name _____

Did an auto accident or work injury prompt this visit? _____ Who is financially responsible for your services _____

Insurance that may pay for your care _____

Your Current Condition

What is the primary reason for today's visit? _____

_____ How long have you had this problem? _____

When it's at its worst, what does it feel like? _____

Was onset gradual or sudden? _____ Have you had same or similar condition before? _____

With what activities does it interfere the most? (Sleep? Work? Etc.) _____

What other doctors have you seen for this condition? _____

What have you done attempting to relieve the condition? _____

Has anyone recommended drugs or surgery for this condition? _____

Please mark the symptoms you now have or have recently had

Occasionally	Frequently	Constantly		Occasionally	Frequently	Constantly		Occasionally	Frequently	Constantly	Women Only
___	___	___	Headaches	___	___	___	Sick After Eating Fats	___	___	___	Irregular Heavy Period
___	___	___	Dizziness	___	___	___	Heartburn	___	___	___	Bladder Leakage
___	___	___	Nervousness	___	___	___	Gas	___	___	___	Cramps
___	___	___	Insomnia	___	___	___	Groggy After Meals	___	___	___	PMS
___	___	___	Upper Neck Pain	___	___	___	Allergic To Some Foods	___	___	___	Breast Tenderness
___	___	___	Poor Concentration Or Memory	___	___	___	Indigestion	___	___	___	Hot Flashes
___	___	___	Hyperactivity	___	___	___	Cravings For Sweets	___	___	___	Miscarriage
___	___	___	Ringing In Ears	___	___	___	Poor Energy	___	___	___	Can't Get Pregnant
___	___	___	Facial Pain Or Numbness	___	___	___	Stiffness In Joints				
___	___	___	Pain Or Numbness In Thumb Or Index Finger	___	___	___	Allergies				
___	___	___	Swollen Throat Glands	___	___	___	Swollen Ankles				
___	___	___	Tonsillitis	___	___	___	High Blood Pressure				
___	___	___	Laryngitis	___	___	___	Complexion Problems				
___	___	___	Shakiness In Hands	___	___	___	Depression				
___	___	___	Lower Neck Pain	___	___	___	Headaches With Nausea And Blurry Vision				
___	___	___	Trouble Staying Warm	___	___	___	Constipation				
___	___	___	Pain Or Numbness In Hands Or Arms	___	___	___	Distended Abdomen				
___	___	___	Arms Feel Heavy	___	___	___	Diarrhea				
___	___	___	Chest Pains or Tightness	___	___	___	Hemorrhoids				
___	___	___	Out Of Breath Easily	___	___	___	Frequent Urination				
___	___	___	Asthma	___	___	___	Bladder Infection				
___	___	___	Bronchitis	___	___	___	Low Back Pain				
___	___	___	Pneumonia	___	___	___	Pain In Hips				
___	___	___	Upper Back Pain	___	___	___	Leg Pain or Numbness				
___	___	___	Cold Sores	___	___	___	Cramps In Legs				
___	___	___	Pain Between Ribs	___	___	___	Painful Urination				
				___	___	___	Bed Wetting				

Have You Had

Cancer ____
Heart Disease ____
Rheumatoid Arthritis ____
Sexually Transmitted Disease ____
AIDS ____
Migraine Headaches ____
Carpal Tunnel Syndrome ____
Thyroid Trouble ____
Hiatal Hernia ____
Colitis ____
Osteoporosis ____
Gall Bladder Trouble ____
Alcoholism ____
Diabetes ____
Epilepsy ____

Many (perhaps even *most*) problems in our bodies start out as short-circuits in our nervous systems. Since almost all of these points of nerve distress are found in the spine, it is very important to know what jolts and accidents may have tilted or twisted your vertebrae from their normal positions. Think hard!

Please describe what happened and in what year (approximately) it took place

Most recent auto accident: _____

Second most recent auto accident: _____

Low back injury from lifting, bending or twisting: _____

Fell roller skating: _____

Slipped on ice: _____

Fell down a stairway: _____

Flew off a bike or motorcycle: _____

Fell off a horse: _____

Tumbled off a ladder or chair: _____

Stood up under something and "clunked" your head: _____

Stiff or painful neck after sleeping wrong: _____

Sports injuries: _____

Repetitive injury to wrist or neck (keyboarding, looking down for hours, etc.): _____

Do you hold the phone receiver by shrugging your shoulder to your ear? _____

Have you ever been put "under" with general anesthetic? _____

Other: _____

The results you hope to achieve through coming to this office

Relieve the immediate pain and discomfort _____

Spine improved enough that it will "hold together" for a few months _____

Spine and nerve system improved as much as possible and maintained in top condition _____

Surgeries you have had

Tonsils _____ Tubes in ears _____ Thyroid _____ Breast _____ Hysterectomy Partial _____ Complete _____

Hemorrhoids _____ Prostate _____ Hernia _____ Other _____

Drugs you take or have taken during the last ten years

Thyroid Medication _____ Birth Control Pills _____ Pain Killers (Advil, Tylenol, Aspirin, etc.) _____ Sleeping Pills _____

Tranquilizers _____ Diuretics _____ High Blood Pressure drugs _____ Corticosteroids _____ Hormones _____

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that the Doctor' Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor's Office for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. Patient affirms that all information given is true and accurate to the best of his/her knowledge

Patient's / Guardian's Signature _____ Date _____

Silverdale Health & Injury Center
Dr. Erwin Gemmer DC, Dr. Theo Gip DC
Dr. Richie Dinubilo
9414 Ridgetop Blvd, Ste 101
Silverdale, WA 98383

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be use to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle.

_____

_____ _____
(Signature) (date)

PROFESSIONAL FEE SCHEDULE

Consultation.....No Charge
Chiropractic Examinations.....$60 - $183
Chiropractic Office Visits (averages).....$55 - $96
Chiropractic X-ray Studies (averages).....$95 - $300
Doctor/ Patient Conference.....$85 - $125

(All fees are standard and primarily based on our professional association's guidelines and on the fee schedule set by the Industrial Commission of Washington.)

Our experience has shown that it is wise to have an understanding with our patients as to our office polices and fees. This form has been prepared for your convenience and information. We offer several methods of payment for your Chiropractic Care at our office and you may choose the plan which best fit your needs. Please read carefully and choose the plan which you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. If special arrangements are necessary please consult with the Doctor. Our main concern is your health and well-being, and we will do our best to help you.

PLAN#1- Insurance-If you have insurance which covers Chiropractic care, we will bill your insurance directly. Please bring us your insurance information, on or before your second visit. Until we have the completed, necessary insurance information to verify chiropractic coverage, you will be required to pay for your care. We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility. Most patients with insurance have a yearly deductible and then have a copay or co-insurance. In the event the insurance check should come to you, you are expected to bring the check to us. Remember, insurance companies balk at "maintenance" and long-term rehabilitation. Usually you will not get much help after your initial corrective care. Most ordinarily "health" policies are designed and intended to only take care of acute problems so you should plan to "get off" insurance and be on your own when you get down to once a week or less (except, possibly, some accident injuries). Ask the front desk about available payment plan options.

PLAN#2- Cash-Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

PLAN#3- Monthly Cash Agreements- For those patients, who qualify, we offer a plan called Care Credit that allows you to start treatment and spread payments over time. Care Credit covers you and your family members' healthcare needs. With Care Credit you will enjoy flexible financing options, no annual fees or prepayment penalties. Ask the front desk for more information. We also offer affordable monthly plans for individuals and families in house. These plans apply to all cases, except Work injury or Auto injury claim.

PLAN#4-INDUSTRIAL—You need to supply us with the accident to your employer, bring in necessary insurance information, and sign industrial forms for billing by second visit. We will bill your insurance directly.

PLAN#5-AUTO INJURY—You need to supply us with the accident report, your car insurance, health insurance, and liable parties insurance, and attorney if applicable. Until necessary insurance information is gathered and verified for chiropractic care, you will be required to pay for your care. We will bill your insurance directly after verification of coverage. In the event the check should come to you, you are expected to bring the check to us.

PLAN#6-MEDICARE—Per established Medicare guidelines please bring us your Medicare information on or before your second visit. We will bill your Medicare directly. In the event the check should come to you, you are expected to bring the check to us. Medicare has a yearly Deductible of $155.00, then covers 80% of the visit cost.

I QUALIFY AND UNDERSTAND PLAN#_____ REQUIREMENTS.

SIGNATURE_____

DATE_____

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA–Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

How your HEALTH INFORMATION may be used To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Silverdale Chiropractic Health and Injury Center

(360) 308-0250

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert A Serious Threat To Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death Or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Effective Date: 9/23/2013

Patient Acknowledgment

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

_____

Patient Signature

Date_____/_____/_____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.