GRAVES CHIROPRACTIC NEW PATIENT INTAKE

Name:_____ Today's Date:_____

Address: _____ City:_____ State:_____ Zip:_____

Cell: _____ Home Telephone: _____ Work: _____

Email Address: _____ ☐ Male ☐ Female

Social Security: _____ Birth Date: _____ Age:_____

Occupation and Employer: _____ Height: ____' ____" Wt: _____

☐ Single ☐ Married Spouse's Name: _____

Have you seen a Chiropractor before? ☐ Yes ☐ No If yes, when? _____ Condition? _____

Whom may we thank for referring you to our office? _____

YOUR HEALTH HISTORY

Please ☒ all symptoms you have ever had, even if they do not seem related to your current problems.

☐ Osteoporosis/ Osteopenia	☐ Dizziness	☐ Fatigue	☐ Nervousness
☐ Herniated Disk	☐ Fainting	☐ Sleeping problems	☐ Stomach upset
☐ Spinal Surgery	☐ Headaches	☐ Mood Swings	☐ Hot flashes
☐ Arteriosclerosis	☐ Neck Pain	☐ Menstrual Pain/Irregularity	☐ Heartburn
☐ Stroke	☐ Neck Stiff	☐ Depression	☐ Cold feet
☐ Heart Attack	☐ Back Pain	☐ Constipation	☐ Cold Sweats
☐ Cancer	☐ Pins and Needles in arms	☐ Thyroid Condition	☐ Cold Hands
☐ Fractures / Broken bones	☐ Pins and Needles in legs	☐ Digestion Problems	☐ Problem urinating
☐ High Blood Pressure	☐ Numbness in fingers	☐ Irritability	☐ Ulcers
☐ Diabetes T1 / T2	☐ Numbness in toes	☐ Asthma	☐ Fever
☐ Currently Pregnant	☐ Autoimmune Disease	☐ Loss of Balance	☐ Ringing in ears

List surgeries with dates: _____

List any medications you are taking: _____

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Paul Graves, D.C., P.A. all insurance benefits, if any , otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____ _____

Patient Signature Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

PAUL GRAVES D.C., PA (GRAVES CHIROPRACTIC)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Legal Duty

We are obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless given written authorization by you, which may revoke in writing at any time. We reserve the right to change our privacy practices and apply revised privacy practices to protect health information. The new notice will be available upon request, in our office, and on our website. This notice takes effect Nov.15thst 2014 and will remain in effect until we replace it. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact our privacy officer at Paul Graves D.C., PA, 7500 Stonebrook Pkwy., Suite 103, Frisco, Texas 75034. Telephone: 972-377-7117. For more information **see** **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Uses and Disclosures of Medical Information

We use and disclose medical information about you for treatment, payment, and/or health care operations. This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by health plans or other entities--such as insurance companies, HMOs and PPOs, managed care organizations, CMS, other governmental or third party payers, or any business associates of the covered entity and their employees for the above entities to perform such functions--for services rendered by us. Copies of your medical information may be delivered to other professionals who are directly or indirectly responsible for your medical care or the payment thereof. We may use or disclose your medical information to notify a family member or another person responsible for your care based on our professional judgment and the circumstances. We may use your medical information to contact you, leave a message, text and/or email to provide appointment reminders, thank you cards, and promotional information. We may use or disclose your medical information for purposes involving public health and safety issues and activities, death, certain requests from your employer, governmental personnel and programs, organ donation, judicial and administrative proceedings, law enforcement, abuse, neglect or domestic violence issues and workers' compensation issues. I give permission to receive treatment in an open room where other patients are also being treated. I am aware that others in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, I will notify the doctor and or staff for a private room.

Individual Rights

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time. You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. We charge a cost-based fee for copying of your paper or electronic records.

Authorization and HIPAA Acknowledgement

Please read carefully and sign/initial here indicated.

I acknowledge I have read and understand the HIPAA policy of Paul Graves, D.C. PA.

_____ _____

Signature of Patient/Legal Guardian Date

_____

Print name of Patient/Legal Guardian

I hereby authorize Paul Graves, D.C. PA, to discuss and disclose any healthcare information including billing/account information on my behalf anytime; to the person(s) listed below: **(If you do not permit anyone access to this information on your behalf, leave the area blank)**

Print Authorized Person's Name	List authorized Party's Relationship to Patient	Patient's Initials
Print Authorized Person's Name	List authorized Party's Relationship to Patient	Patient's Initials
Print Authorized Person's Name	List authorized Party's Relationship to Patient	Patient's Initials

Signature of Paul Graves, D.C. PA
Employee as Witness

Date

Questions and Complaints

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with appropriate address upon request.

If you have any questions or complaints, please contact:

Dr. Paul Graves Privacy Officer, Sandy Bowen Security Officer at 7500 Stonebrook Pkwy, Suite 103 Frisco, Texas 75034, (972) 377-7117