Sitzmann Chiropractic, LLC (864) 458-8888 Greenville, SC

Patient Information Sheet

SSN_____ Last Name_____ First Name_____ MI___

Gender ____M ____F D. O. B. ___/___/____ Marital Status ____S ___M ___D ___W

How did you hear about our office?_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Email_____

Language ___English ___Spanish ____Other:_____

Employer Name_____ Address_____

Work Phone_____ Employment Status ___Full ___Part ____Retired ___Disabled

Emergency Contact Information:

Name_____ Phone_____ Relationship_____

Primary Insurance

Insurance:_____
Policy Number_____
Group Number_____
Insured Name*_____
Relation to Patient_____
Insured D.O.B.*_____

Secondary Insurance

Insurance_____
Policy Number_____
Group Number_____
Insured Name*_____
Relation to Patient_____
Insured D.O.B.*_____

*If your insurance is in another family member's name the above fields would be that family member's information

RELEASE OF INFORMATION AND PATIENT CONSENT

I authorize Sitzmann Chiropractic LLC to release any information acquired in the course of my medical examination and treatment. I authorize all information to be released to my insurance company, third party payers, case utilization, managed care review companies, Health Care Financing Administration. I further authorize information to be released to all other Sitzmann Chiropractic LLC affiliated institutions or individuals who will be providing healthcare services to me.

I hereby authorize Sitzmann Chiropractic's staff to give the following people information concerning my test results, health status, appointment times, and procedure information. Name_____

FINANCIAL AGREEMENT

INSURANCE : I understand and agree that health insurance policies are an arrangement between my insurance carrier and myself. I understand that Sitzmann Chiropractic will file all primary insurance claims for me. I authorize payment of medical benefits directly to Sitzmann Chiropractic, LLC. Furthermore, I agree that if my insurance does not pay for my claim(s), it will become my responsibility.

SELF PAY : We request full payment at the time treatment was rendered. *To financially assist you and your family members, we offer pre-pay, wellness, student, and child plans*. We are happy to accept cash, check, or credit card.

**Name_____ Signature(Guardian)_____ Date_____

Sitzmann Chiropractic, 224 Feaster Rd. Suite C, Greenville, SC 29615
Ph. (864) 458-8888 Fax (864) 458-8848

INFORMED CONSENT

The nature of the chiropractic manipulation: I will use my hands or an instrument to move the joints of your body; this may result in an audible "pop" or "click".

The material risks inherent in an adjustment: As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

The probability of those risks: Fractures are rare and can result from an underlying weakness in the bones. The other complications are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

Ancillary treatments recommended: _____N/A_____

Risks involved with the recommended ancillary treatments:
_____N/A_____

Other treatment options for your condition include: Medical care with prescription drugs, self management with over-the-counter medication, rest, and/or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self-dosages, and surgical risks including complications from the procedure and the anesthesia.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the chiropractic adjustment and the related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it was in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Patient Printed Name _____ **Date** _____

Patient Signature _____

HIPPA Notice of Privacy Practices

(YOUR NAME) _____

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or conditions and related health care services.

1. **Uses and Disclosures of Protected Health Information**

Uses and Disclosure of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your heath care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

OVER

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protect health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

PRINT NAME: _____ **SIGNATURE:** _____ **DATE:** _____

Sitzmann Chiropractic, LLC (864) 458-8888 Greenville, SC

Patient Medical History

Patient Name:_____ D.O.B. _____

Current Condition:

Describe Major Complaint(s):_____

Began When? ___/___/____ Describe how this began:_____

Height: _____ Weight: _____ Drug Allergies: _____

Current Prescription Medications:

_____

Past Medical History: Please list all current medical issues including surgeries in the last 10 years

_____

_____

(If necessary, continue on back of page)

Social History:

How is your diet? ___Poor ___Average ___Good diet ___Excellent Diet

Do you exercise? ___No ___Yes→ If yes, how often? _____

Do you currently smoke? ___Never ___No ___Yes → If yes, how many packs per day _____

Do you drink alcohol? ___No ___Yes → If yes, how often? _____

Family History:

Do your parents currently have or have they ever had any of the following health problems:

___Alzheimer's ___Arthritis ___Asthma ___Cancer: _____

___CAD ___Cholesterol Issues ___Depression ___Diabetes ___Hypertension ___Migraines

___Obesity ___Osteoporosis ___Kidney Disease ___Stroke ___Thyroid Disorder ___Unknown

List all Other Family History:

___Alzheimer's ___Arthritis ___Asthma ___Cancer: _____

___CAD ___Cholesterol Issues ___Depression ___Diabetes ___Hypertension ___Migraines

___Obesity ___Osteoporosis ___Kidney Disease ___Stroke ___Thyroid Disorder ___Unknown

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my health.

Print Name_____ Signature_____ Date_____