

Ehlers Chiropractic Center

Confidential Patient Information

Name: _____ Hm Phone: _____ Wk/Cell Phone: _____

Address: _____ City: _____ St: _____ Zip: _____

Date of Birth: _____ Marital Status (circle one) M S D W Age _____

Social Security Number _____ - _____ - _____ E-mail Address _____

Occupation: _____ Employer: _____

Work Address: _____ City, St, Zip: _____

Spouse's Name: _____ # of Children: _____

Who may we thank for referring to our office: _____

Have you ever had Chiropractic care before? Yes No Date: _____

Is this injury/illness related to: Automobile Accident

Date/Time: _____ Location: _____

Your Auto Insurance Co: _____ Phone: _____

Third Party Auto Insurance Co: _____ Phone: _____

Due to changes in health insurance fees, patient self billing has become a much more cost effective way for you, the patient, to get reimbursement for your care. Self billing allows us to keep our fees low so you can get the care you need without any added cost. Therefore, our policy is that all payment is due at the time of service and bills will no longer be sent to your insurance provider. Statements will be provided for individuals to submit their own bills ensuring that as your insurance provider pays for your care, they will send the reimbursement check directly to you.

All charges are due when services are rendered...

Method of payment () Check () Cash () Credit Card () Care Credit

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

RELIEF CARE

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

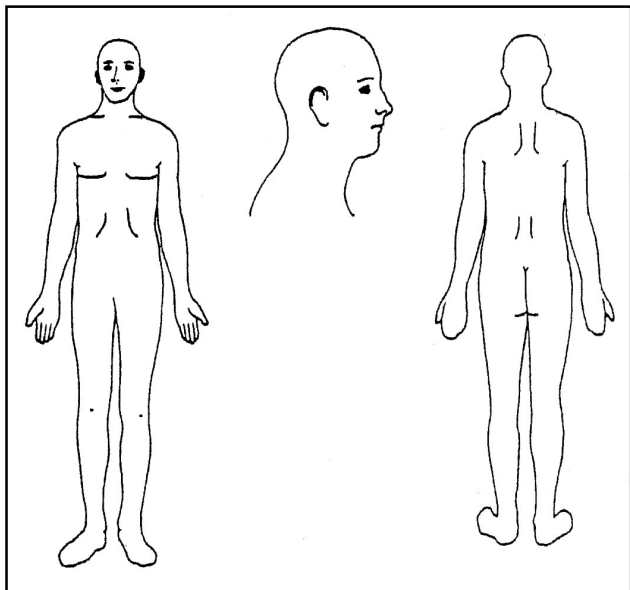
CORRECTIVE CARE

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

PLEASE MARK AN X ON THE DIAGRAM BELOW WHERE YOUR PROBLEMS ARE

What hurts and how long has it hurt?

1. _____
2. _____
3. _____
4. _____



When do you think these problems originally started?

1. _____
2. _____
3. _____
4. _____

List other Chiropractic or Medical Doctors you have consulted for these conditions.

1. _____
2. _____
3. _____
4. _____

Check any of the following you have had in the six months:

- | | |
|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Sinus Congestion/ Allergies | <input type="checkbox"/> Frequent Nausea/ Vomiting |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Abdominal Cramps |
| <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Poor / Excessive Appetite |
| <input type="checkbox"/> Lung Problems / Congestion | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Painful / Excessive Urine |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Discolored Urine |
| <input type="checkbox"/> Prostate/ Sexual Dysfunction | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Menstrual Cycle Dysfunction | <input type="checkbox"/> Cancer |

Are you pregnant? Yes No Not Sure

Parent or Legal Guardian Authorizing Care: _____

THANK YOU FOR ALLOWING US TO SERVE YOU!

I authorize Ehlers Chiropractic Center to render necessary services to me and understand that I am responsible for all charges incurred.

Patient Signature: _____ Date: _____

Ehlers Chiropractic Center

Dr. Robert W. Ehlers
673-A Merchant Street
Vacaville, CA 95688
Tel: 707-446-0700
Fax: 707-447-0800

Financial Policy

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our financial policy.

There will be no cost to you for the first visit.

Payment for services is due upon receipt of our statement unless alternative arrangements have been approved in advance by our staff. We accept cash, check and Visa/Mastercard.

Balances older than 60 days may be subjected to interest charges of 1.5% per month. Additional collection fees will be charged on return checks.

Some services may not be covered by your insurance. In such cases, we will bill the patient directly as allowed.

We will gladly discuss any questions relating to your insurance. Please realize, however, that:

1. One of the great things about our office is we will be happy to give you a statement showing the services rendered. Depending on your insurance you may be reimbursed for these services.
2. For those of you who are covered by an HMO or PPO, your insurance is a contract between you and your insurance company. We are, not a party to that contract. Therefore, you are responsible for payment in full.
3. Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. You are responsible for payment for those services.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we ask you to contact us promptly so that we may assist you in making arrangements that will allow you to meet your financial responsibilities with our office.

If you have any questions regarding the above information, or any questions regarding your insurance coverage, please do not hesitate to ask us. We will be happy to assist you.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

Signed: _____

Date: _____

Ehlers Chiropractic Center

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

This practice is committed to maintaining the privacy of your Protected Health Information (PHI), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

CONSENT

The practice may use and/or disclose your PHI provided that it first obtains a valid Consent signed by you. The Consent will allow the Practice to use and/or disclose your PHI for the purposes of:

- (a) **Treatment** – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice’s staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for kidney problems may need to know the results of your latest physical examination by this office.
- (b) **Payment** – In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.
- (c) **Health Care Operations** – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose you PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice’s personnel in providing care to you.

NO CONSENT REQUIRED

The practice may use and/or disclose your PHI, without a written Consent from you, in the following instances:

- (a) **De-identified Information** – Information that does not identify you and, even without your name, cannot be used to identify you.
- (b) **Business Associate** – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.
- (c) **Personal Representative** – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
- (d) **Emergency Situations** – For the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
- (e) **Communication Barriers** – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.
- (f) **Public Health Activities** – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.
- (g) **Abuse, Neglect or Domestic Violence** – To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.
- (h) **Health Oversight Activities** – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community’s health care system.

YOUR RIGHTS

You have the right to:

- (a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer. Please allow a reasonable processing time for the change in our procedure to be completed.
- (b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request (within 60 days) unless the information is needed in order to provide you with emergency treatment.
- (c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.
- (d) Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.
- (e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. The Practice has 60 days to notify you acceptance or refusal to amend. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.
- (f) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. Practice will act on the request for an account of disclosure within 60 days. The request must state a time period which may not be longer than 6 years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a 12-month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.
- (g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.
- (h) Complain to the Practice or the Secretary of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.
- (i) To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer, Dr. Hans Freericks at (510) 797-4796 or via fax at (510) 797-8700.

PRACTICE'S REQUIREMENTS

The Practice:

- (a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- (b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the following State statutes:
 - 1) Is required to abide by the terms of this Privacy Notice.
 - 2) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice Provisions effective for all of your PHI that it maintains.
 - 3) Will distribute any revised Privacy Notice to you prior to implementation.
 - 4) Will not retaliate against you for filing a complaint.

This Notice is in effect as of 4/14/03. This notice, and any alterations or amendments made hereto, will expire seven years after the date upon which the record was created.

Ehlers Chiropractic Center

Dr. Robert W. Ehlers D.C.
Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge you have received our Notice of Privacy Practices, dated 02/01/03. This allows our use and disclosure of your protected health information to ONLY carry out treatment, payment activities, and healthcare operations.

Signature: _____

Date: _____

If this Acknowledgement is signed by a personal representative of behalf of the patient, complete the following:

Personal Representative's Name:

Relationship to Patient: _____