New Patient Health Status Date: ____/____/_____

Patient Name_____ Date of Birth ____/____/_____
Home Address _____ City _____ State_____ Zip _____
Home Phone _____ Cell _____ Gender _____
S.S. # _____ Age _____ Email _____
Circle One: Minor Single Married Divorced Widowed Separated
Employer _____ Occupation _____
Work phone _____
Spouse name _____
Emergency Contact _____

Health Ins. Co. _____ Policy Holder _____
Policy Holder Date of Birth_____

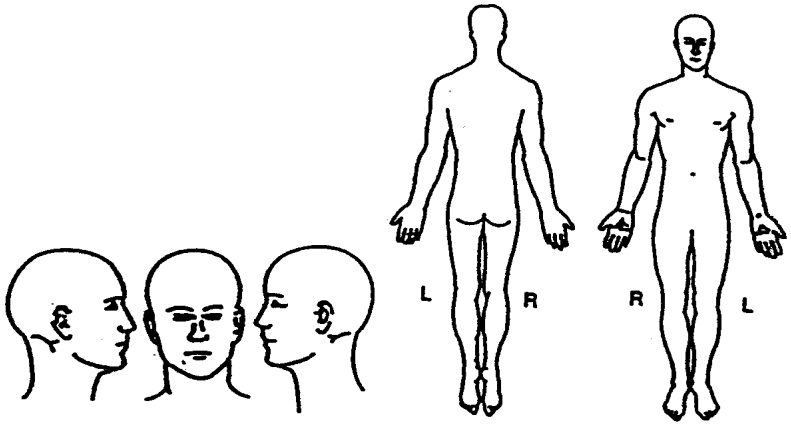
Symptom(s) 1. _____ 2. _____ 3. _____
When did symptoms appear? _____
Is this condition getting worse? Yes No Unsure
Rate the severity of your pain on a scale from **1-10** with "1" indicating mild pain and "10" severe pain _____

Type of Pain*: circle ALL that apply.*
Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramping
Swelling Stiffness Other: _____
How often do you experience symptoms? _____
Are symptoms constant? Yes No Symptoms worse in AM or PM? _____

Circle any activities or movements that are painful to perform:
Working Sleeping Sitting Standing Walking Bending Lying Down
Recreation Other_____

What health care (if any) have you received for this problem? Circle all that apply
None Medication Surgery Physical Therapy Chiropractic Acupuncture Massage
Other _____

Please place an "X" over areas of pain, numbness, weakness, or tingling →



Is this condition due to an accident? Yes ____ No ____ Date: ____/_____/_____

Type of accident: auto ____ work ____ home ____ sports ____ other: _____
To whom have you made a report of your accident?
Auto Insurance ____ Employer ____ Worker's Comp. ____ other: _____
Attorney name (if applicable) _____
Have you lost any time from work? _____ Dates: _____

Mark YES or NO to indicate if you have had or currently have any of the following:

AIDS/HIV	Y N	Goiter	Y N	Parkinson's Disease	Y N
Alcoholism	Y N	Gonorrhea	Y N	Pinched Nerve	Y N
Allergy Shots	Y N	Gout	Y N	Pneumonia	Y N
Anemia	Y N	Heart Disease	Y N	Polio	Y N
Anorexia	Y N	Hepatitis	Y N	Prostate Problem	Y N
Appendicitis	Y N	Hernia	Y N	Prosthesis	Y N
Arthritis	Y N	Herniated Disc	Y N	Psychiatric Care	Y N
Asthma	Y N	Herpes	Y N	Rheumatoid Arthrosis	Y N
Bleeding Disorder	Y N	High Blood Pressure	Y N	Rheumatic Fever	Y N
Breast Lump	Y N	High Cholesterol	Y N	Scarlet Fever	Y N
Bronchitis	Y N	Kidney Disease	Y N	STD	Y N
Bulimia	Y N	Liver Disease	Y N	Stroke	Y N
Cancer	Y N	Measles	Y N	Suicide Attempt	Y N
Cataracts	Y N	Migraine Headaches	Y N	Thyroid Problems	Y N
Chemical Dependency	Y N	Miscarriage	Y N	Tonsillitis	Y N
Chicken Pox	Y N	Mononucleosis	Y N	Tuberculosis	Y N
Diabetes	Y N	Multiple Sclerosis	Y N	Tumors, Growths	Y N
Emphysema	Y N	Mumps	Y N	Typhoid Fever	Y N
Epilepsy	Y N	Osteoporosis	Y N	Ulcers	Y N
Fracture	Y N	Pacemaker	Y N	Vaginal Infections	Y N
Glaucoma	Y N			Whooping Cough	Y N
				Other:	

Family History:

	Cancer	Diabetes	Heart Trouble	High Blood Pressure	Stroke	Kidney Disease	Anemia	Mental Illness	Headaches	Osteoporosis	Arthritis	Joint Problems	Scoliosis	Back Problems	Disc Problems	Congenital Defects	Genetic Disease	Other	Deceased
Father																			
Mother																			
Siblings																			
Children																			

Exercise:	Work Activity:	Habits:
____ None	____ Sitting	____Smoking Packs/Day _____
____ Moderate	____Standing	____Alcohol Drinks/Week _____
____Daily	____Light Labor	____ Coffee/Caffeine Drinks Cups/Day _____
____ Heavy	____ Heavy Labor	____High Stress Level Reason _____

Are you pregnant: YES NO **Due Date**: _____

Previous Injuries/Surgeries	**Description**	**Date**
Falls	_____	_____
Head/Injuries Falls	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications:	Allergies:	Vitamins/Herbs/Minerals:
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name:		
Pharmacy Phone Number:		

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this 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 this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Signature: _____ Date: _____/_____/_____

Authorization to Release Protected Health Information

Allied Chiropractic and Wellness 110 Veterans Blvd. Suite 130 Metairie, LA 70005 Office (504) 321-0411 Fax (504) 321-0412		For Office Use Only: PHI: __Mailed __ Picked Up __Faxed ID Verified: __Yes __No Date Received: _____ Date Processed: _____ Processed By: _____

Please complete this form in its entirety so that we may fulfill your request promptly.

Patient's Name: _____ Date of Birth: _____

Authorization for use/disclosure of information:

I am the patient, or legally authorized representative of the patient, listed above. I voluntarily authorize and direct my health care provider **Allied Chiropractic and Wellness** to use or disclose my health information during the term of this authorization to the recipient that I have identified below:

Please **check** those that apply:

- ○ Myself
- ○ Another individual: _____
- ○ Facility/Company/Organization: _____
  Street Address: _____
  City/State/Zip: _____
  Telephone #: _____ Fax: _____
  Email Address: _____

Purpose of Disclosure:

I understand that the specific purpose of this authorization is for:

Consultation with or transfer of care to another health care provider
Attorney
Insurance Company
Workers' Compensation
CAL

Information to be disclosed:

This authorization permits the above provider to disclose the following medical records:

- ○ My complete patient file, including information relating to any medical, history, mental or physical condition and any treatment received by me.
- ○ All of my health information described above, except for the following:

  _____

Inspect/Copy:

I understand that I have the right to inspect or copy the protected health information to be used or disclosed under this authorization.

Re-disclosure:

I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state laws governing the use and disclosure of my health information.

Refusal to sign/right to revoke:

I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation:

I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to Allied Chiropractic and Wellness at 110 Veterans Blvd., Suite 130, Metairie, LA 70005. The revocation will be effective immediately upon the clinic's receipt of my written notice, except that the revocation will not have any effect on disclosures that relied upon this authorization and were made prior to receipt of my written revocation.

_____	_____	_____
Signature	**Date**	**Printed Name**

If the patient is unable to sign this authorization, please complete the information below. By signing this form for someone else, you-as the parent, guardian, a party acting in loco parentis, or legal representative- are indicating that you have the legal authority to act on the patient's behalf and that you are not prohibited by court order from having access to the requested medical records.

_____	_____	_____
Name of Guardian/Representative	**Date**	**Legal Relationship**

INFORMED CONSENTMENT FOR EXAMINATION AND TREATMENT

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected, but rather I wish to rely on the doctor to choose and/or recommend a best course treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures for my condition and for any future conditions for which I seek treatment.

_____ _____

Patient's Name (Printed) Patient's Signature

_____ _____

Date Relationship or authority if not signed by the patient

_____

Witness

INTEGRATIVE DRY NEEDLING CONSENT FORM

Integrative Dry Needling involves placing a small needle into the tissue that is tender with the intent to normalize the physiology of the area and regain homeostasis, which will improve the function of the musculoskeletal system resulting in symptom reduction.

Integrative Dry Needling is a valuable treatment for musculoskeletal pain. Like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent to treatment.

Risks of the procedure:

Though unlikely there are risks associated with this treatment. The most serious risk associated with Dry Needling is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern.

Other risks may include bruising, infection and nerve injury. **Please notify your provider if you have any conditions that can be transferred by blood.** Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from Dry Needling is unlikely.

Please consult with your practitioner if you have any questions regarding the treatment above.

Do you have any known **metal implants, disease, or infection** that can be transmitted through bodily fluids?

YES_____ NO_____

If you marked YES, Please specify below and discuss with your practitioner.

_____

Please print your name

Signature Date

FINANCIAL POLICY

We welcome you as a new patient and want you to be clear on your financial responsibility for care at our clinic.

If you have health insurance, as a courtesy, this office will provide you with your insurance benefits and will file all insurance claims. This will be explained to you and the terms of your coverage will be in your chart. You will be responsible for any and all costs associated with your deductible, co-payments, and co-insurance. At the beginning of each month, statements are mailed and at times insurance claims are still pending. If there is a question about your personal balance, please feel free to contact our insurance department at your convenience at (504) 321-0411. Please note that this may be done by telephone, or feel free to do this at the time of one of your therapy sessions. You are also responsible for any non-covered expenses such as ice packs, vitamins, back braces, pillow, etc. You can pay this on each visit or on a monthly basis.

Our office accepts Visa, MasterCard, American Express, Personal Checks, and Cash. In the event of a returned check, you will be charged a $30.00 returned check fee.

Our office requires 24 hour notice of any changes in your appointment. In the event of cancelled or no show appointments, we reserve the right to charge a $ 25 appointment fee.

Patient signature required: I have read the above and understand and agree that I am responsible for any and all charges that are not reimbursed by my health insurance.

For questions please contact billing office (504) 321 – 0411

_____ _____

Patient's Signature Date

_____ _____

Chiropractic Assistant Date

Summary of Privacy Practices

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full length Notice is available upon request.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As a patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail, please refer to the Notice of Privacy Practices):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our practice more efficiently and ensure all our patients received quality care
- For research
- To avert a serious threat to health or safety
- For organ or tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filling a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect a copy
- The right to request restrictions
- The right to amend
- The right to a paper copy of this notice
- The right to an accounting of disclosures
- The right to request confidential communications

For more information about these rights, please see the detailed Notice of Privacy Practices that is available upon request.

This form will be retained in your medical records.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name: _____ Date of Birth: _____

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Allied Chiropractic and Wellness.

I understand that the Notice describes the use and disclosures of my protected health information by Allied Chiropractic and Wellness and informs me of my rights with respect to my health information.

_____ _____

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

_____ _____

Today's Date

If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- ○ The patient refused to sign.
- ○ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ○ Communication barriers prohibited obtaining the acknowledgment.
- ○ Other (please specify): _____

_____ _____

Employee Name

Today's Date