Confidential Practice Member Information

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely.

Date: ____________________ Home Phone: ______________________

Cellular Phone: ___________________________

Email Address: ___________________________

Name: ______________________________________ SSN: _________________________________

Street: ________________________________ City/State: ______________________ Zip: ____________

Gender: M / F Age: _____ Birth Date: _____________

Marital Status: Single / Married / Divorced / Widowed # of Children: _________

Occupation: _________________________________ Employer: ___________________________________

Address: __________________________________________ Office Phone: _______________________________

Name of Spouse: _____________________________ Spouses Birth date: ____________________________

Occupation: _________________________________ Employer: ___________________________________

Who can we thank for referring you here today? _______________________________________________

Have you ever been to a Chiropractor before? Y / N

**Health Concerns:**

| Health Concerns: In Order of Importance | Severity 1=Mild 10=Unbearable | How long have you had this? | Did this start with an injury? | Have you had this before? | Is this constant or comes/goes? |
|---|---|---|---|---|---|
| 1.______________________ | _____________ | ____________ | _____________ | ________ | _____________ |
| 2.______________________ | _____________ | ____________ | _____________ | ________ | _____________ |
| 3.______________________ | _____________ | ____________ | _____________ | ________ | _____________ |

How do your health concerns affect your daily life (brushing teeth, getting dressed, etc.)?______________________

_______________________________________________________________________________________________

_________________________________________________________________________________

**Main Complaint History:**

1. How would you describe the pain?

☐ Sharp ☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull ☐ Stiffness
☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness ☐ Shooting

2. Does the pain travel anywhere else? ☐ Yes ☐ No Describe: ____________________

3. How often is this present?

☐ Constant (81 - 100%) ☐ Frequent (51 - 80%) ☐ Occasional (26 - 50%) ☐ Intermittent (25% or less)

4. Since it started, has the pain gotten better, worse or stayed the same? ______________________________

5. What makes your complaint worse?

☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Exercise (Moving) ☐ Lying Down ☐ Other

If other, please explain: ______________________________________________________________________________

6. Have you seen anyone else for this health concern? (Medical Doctor, Chiropractor, etc.) If so, who? _________

______________________________________________________________________________________________

7. Please list all medications you are taking and for what:

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

8. Please list any broken bones, surgeries or hospitalizations you have had and when:

______________________________________________________________________________________________

______________________________________________________________________________________________

9. Please list any auto accidents you have been involved in:

______________________________________________________________________________________________

______________________________________________________________________________________________

10. Please check off any of the conditions below that you (or your family) have or have had in the past:

| | Yourself | Spouse | Children | Mother | Father |
|---|---|---|---|---|---|
| Asthma | | | | | |
| Arthritis | | | | | |
| TMJ | | | | | |
| Acid Reflux | | | | | |
| Epilepsy | | | | | |
| Ulcers | | | | | |
| Dizziness | | | | | |
| Headaches | | | | | |
| Vertigo | | | | | |
| Nervousness | | | | | |
| Menstrual | | | | | |
| Nausea | | | | | |
| Lupus | | | | | |
| Fatigue | | | | | |
| Numbness | | | | | |
| Ear Infections | | | | | |
| Sciatica | | | | | |
| Cardiac Condition | | | | | |
| Migraines | | | | | |
| Sinus | | | | | |
| Kidney Condition | | | | | |
| Liver Disease | | | | | |
| Fainting | | | | | |
| Disc Problems | | | | | |
| Stiffness | | | | | |
| Irritable Bowel | | | | | |
| Stomach Condition | | | | | |

**IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE SIGN BELOW**

Name of Minor/Child: ________________________

I hereby authorize Dr. Joseph Minnich, Dr. Jennifer Minnich and/or the staff of Revelation Chiropractic to perform a diagnostic evaluation, radiographic evaluation and/or chiropractic care and adjustments to my minor/child.

As of this date I have legal authority to select health care services for my minor/child. If at any point, this authority changes I will immediately notify Revelation Chiropractic.

Signed:______________________________ Relation to Minor/Child:_____________

Team Witness:______________________ Date:________________________________

# X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAYS IN OUR FILES.
THE FEE FOR COPYING YOUR X-RAYS IS $15.00 PER VIEW. THIS FEE MUST BE PAID IN ADVANCE.

X-RAYS WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY.

PLEASE NOTE: X-RAYS ARE UTILIZED N THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF REVELATION CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.
BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

______________________________ ______________________________
PRINT YOUR NAME HERE DATE

______________________________ ______________________________
SIGNATURE YOUR AGE

**FEMALE PRACTICE MEMBERS ONLY:** TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT REVELATION CHIROPRACTIC.

______________________________ ______________________________
SIGNATURE DATE

DO NOT WRITE BELOW THIS LINE ∞ DO NOT WRITE BELOW THIS LINE

| □ AP Lumbar | | | |
|---|---|---|---|
| cm | KvP | Time | mAs |
| □ 20-21 | □ 78 | □ 1/15 | 20 |
| □ 22-23 | □ 82 | □ 2/20 | 30 |
| □ 24-25 | □ 86 | □ 3/20 | 45 |
| □ 26-27 | □ | □ 4/20 | 60 |
| □ 28-29 | | □ 5/20 | 75 |
| □ 30-31 | | □ 6/20 | 90 |
| □ 32-33 | | □ 8/20 | 120 |
| □ 34-35 | | □ 10/20 | 150 |
| □ 36-37 | | □ 12/20 | 180 |
| □ 38-39 | | □ 16/20 | 240 |
| □ 40-41 | | □ 1 | 300 |
| □ 42-43 | | □ 1 4/10 | |
| Size 14X17 | mA 300 | □ 2 | |

| □ Lateral Lumbar | | | |
|---|---|---|---|
| cm | KvP | Time | mAs |
| □ 26-27 | □ 90 | □ 1/15 | 13 |
| □ 28-29 | □ 94 | □ 2/20 | 20 |
| □ 30-31 | □ 100 | □ 3/20 | 30 |
| □ 32-33 | □ | □ 4/20 | 40 |
| □ 34-35 | | □ 5/20 | 50 |
| □ 36-37 | | □ 6/20 | 60 |
| □ 38-39 | | □ 8/20 | 80 |
| □ 40-41 | | □ 10/20 | 100 |
| □ 42-43 | | □ 12/20 | 120 |
| | | □ 16/20 | 160 |
| | | □ 1 | 200 |
| | | □ 1 4/10 | |
| Size 14X17 | mA 200 | □ 2 | |

| □ AP Thoracic | | | |
|---|---|---|---|
| cm | KvP | Time | mAs |
| □ 16-17 | □ 78 | □ 1/20 | 15 |
| □ 18-19 | □ | □ 1/15 | 20 |
| □ 20-21 | | □ 2/20 | 30 |
| □ 22-23 | | □ 3/20 | 45 |
| □ 24-25 | | □ 4/20 | 60 |
| □ 26-27 | | □ 5/20 | 75 |
| □ 28-29 | | □ 6/20 | 90 |
| □ 30-31 | | □ 8/20 | 120 |
| Size 10X12 | mA 300 | | |

| □ Lat Thoracic | | | |
|---|---|---|---|
| cm | KvP | Time | mAs |
| □ 22-23 | □ 80 | □ 1/15 | 20 |
| □ 24-25 | □ | □ 2/20 | 30 |
| □ 26-27 | | □ 3/20 | 45 |
| □ 28-29 | | □ 4/20 | 60 |
| □ 30-31 | | □ 5/20 | 75 |
| □ 32-33 | | □ 6/20 | 90 |
| □ 34-35 | | □ 8/20 | 120 |
| □ 36-37 | | □ 10/20 | 150 |
| Size 10X12 | mA 300 | | |

| □APOM | | | |
|---|---|---|---|
| cm | KvP | Time | mAs |
| □ 14-15 | □ 70 | □ 1/15 | 20 |
| □ 16-17 | □ | □ 1/12 | 25 |
| □ 18-19 | | □ 2/20 | 30 |
| □ 20-21 | | □ 3/20 | 45 |
| □ 22-23 | | | |
| | mA 300 | Size 10X12 | |

| □ Lat Cerv | | □Flex/Ext | |
|---|---|---|---|
| cm | KvP | Time | mAs |
| □ 10-11 | □ 78 | □ 1/20 | 15 |
| □ 12-13 | □ | □ 1/15 | 20 |
| □14-15 | | □ 1/12 | 25 |
| □16-17 | | □ 2/20 | 30 |
| | | □ 3/20 | 45 |
| mA 300 | Size 10X12 | | |

| □Low Cerv | | | |
|---|---|---|---|
| cm | KvP | Time | mAs |
| □ 14-15 | □ 70 | □ 1/15 | 20 |
| □ 16-17 | □ | □ 1/12 | 25 |
| □ 18-19 | | □ 2/20 | 30 |
| □ 20-21 | | □ 3/20 | 45 |
| □ 22-23 | | | |
| | mA 300 | Size 10X12 | |

| □ Dr. Joseph Minnich |
|---|
| □ Dr. Jennifer Minnich |
| _____ CA Initials |
| Notes: |

Practice Member Information (Must be Completed Before Services can be Rendered)

NAME:______________________________________________________________
First Middle Last

ADDRESS:___________________________________________________________
Street Apt. City State Zip

PHONE: HOME:_______________ CELL:_________________ WORK:____________

SOCIAL SECURITY #:_______________________ MARITAL STATUS:______________

DATE OF BIRTH:__________________________

EMERGENCY CONTACT:_________________________ PHONE #:_________________

**NAME OF PRIMARY INSURANCE CARRIER:**________________________________

NAME OF INSURED:_______________________ INSURED DATE OF BIRTH:________

INSURED SOCIAL SECURITY #:_______________

**NAME OF SECONDARY INSURANCE CARRIER:**______________________________

NAME OF INSURED:_______________________ INSURED DATE OF BIRTH:________

INSURED SOCIAL SECURITY #:_______________

INSURANCE POLICIES AND FEE SCHEDULES:

- **Consultation** – includes practice member history. This service is complimentary.
- **Examination (new practice member or established)** - includes one or more: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check. $50 - $75.
- **Chiropractic Adjustment** – The actual re-alignment of the vertebral done by hand. Often a sound will be heard, but if there is no auditory result it does not mean that the adjustment has not taken place. $40 - $60.
- **X-Rays** – Specific x-rays views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care $40 per view.

Release of Authorization / Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits directly to Joseph Minnich, DC or Jennifer Minnich, DC. I agree that this authorization will cover al lservices rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed:___________________________________ Date:_______________

## Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor – practice member relationship, it is our wish to provide each practice member with a set of parameters and declarations that will facilitate the goal of optimum health through Pure Principled Chiropractic Care.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home, and self-care, etc., is essential to maximum healing and optimal health \ through chiropractic.
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

I ________________________ have read and fully understand the above statements.
(PRINT NAME)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

__________________________________________ ________________
(Signature) (Date)

## NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

**Uses and Disclosures**

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment. *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations. *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

Appointment Reminders. *Example:* Your name, address and phone number and health care records may be used to contact you regarding appointment reminders (such as voicemail messages, postcards or letters), information about alternatives to your present care, or other health related information that may be of interest to you.

In the following cases we never share your information unless you give us written permission: Marketing purposes, sale of your information, most sharing of psychotherapy notes. In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**:

Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an “open adjusting room” in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

**Others Involved in Your Healthcare**: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

**Communication Barriers and Emergencies**: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

EXCEPT AS INDICATED ABOVE, YOUR HEALTH INFORMATION WILL NOT BE USED OR DISCLOSED TO ANY OTHER PERSON OR ENTITY WITHOUT YOUR SPECIFIC AUTHORIZATION, WHICH MAY BE REVOKED AT ANY TIME. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making

employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

**Patient Rights**

Right to Request Restrictions. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction. Your request must be made in writing to our Privacy Official. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Right to Receive Confidential Communications. You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled. Your request to receive confidential communications must be made in writing to our Privacy Official.

Right to Inspect and/or Copy. You have the right to inspect, copy and request amendments to your health records including electronic health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.

Right to Receive an Accounting. You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to receive an accounting must be made in writing to our Privacy Official.

Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request. We are obligated to notify you if there is a breach of your PHI unless there is a low probability of PHI compromise.

**Complaints**

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint.

All questions concerning this Notice or requests made pursuant to it should be addressed to:
Privacy Officer, Revelation Chiropractic: 6360 Tylersville Rd. Suite G, Mason, OH 45040
I do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

________________________ ________________________________ ___________________

Patient Name Patient Signature Date

___________________________________________________________________________________________

Name of Personal Representative Signature of Personal Representative Date

_________________________________

Legal Authority of Personal Representative

**EFFECTIVE DATE OF NOTICE:**

# INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. The level of risk is most often very minimal. Yet, in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain / strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to stroke.

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

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I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE MY CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY, AND TO THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

________________________________________
Print Practice Members Name

________________________________________ __________________
Signature (If minor / child, Guardian please sign) Date

________________________________________
Relationship to minor / child

________________________________________ __________________
Witness Signature (Office Staff) Date