CONFIDENTIAL PATIENT INFORMATION

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist. **PLEASE PRINT.**

Today's Date_____

Name _____ Home Phone _____Cell Phone _____
Address _____ City _____State _____ Zip _____
Email Address _____
Who may we contact in case of emergency?_____ Ph # _____

Age ____ Birth date _____ Marital Status : S M W D No. of children _____

Your employer _____ Occupation _____Years on job ____
Employer Address _____ City _____ State _____Zip _____
Office Phone _____Your SS#__ _____ Driv Lic # _____
Do you have health insurance? YES _____ NO_____ Plan/Group _____
Insurance Company _____
Do you have other health insurance? YES _____ NO _____
Insurance company and Group # _____

Name of Spouse or Parent _____Birth date _____
Employer_____Address_____
City _____ State _____ Zip _____ Office phone_____
Spouse SS# _____ Driv Lic # _____

Please circle one payment type: Cash Check Mastercard/Visa

Describe the Major Complaints that bring you to our office _____
_____

Who referred you to our office? _____

Is your condition due to an accident? YES ___ NO___ Date of Accident_____
Type of accident? Auto ____ Work/On Job ____ At Home ____ Other _____
Have you been in an Auto Accident ? Past year ___ Past 5 years ___Over 5 years ___ Never ___

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____
Spouse or Guardian's Signature _____ Date _____

Notice to our new patients: Full payment of services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.
Insurance Cases: On all insurance the deductible must be met in the beginning unless prior arrangements are made.

HIPAA HAPPENINGS*

HUGHES FAMILY CHIROPRACTIC

Patient Authorization regarding Chiropractic care being provided in an "Open Adjusting" environment:

It is the practice of this office to provide Chiropractic care in an "open adjusting" environment. "Open Adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for **ONGOING** care and is **NOT** the environment used for taking patient histories, performing examinations or presenting reports of finds. These procedures are completed in a private, confidential setting. The "open adjusting" environment affords us the opportunity to educate and adjust more efficiently.

We are requesting this authorization from you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us, we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive, as well as to enhance your access to quality health care and health information. It is our focus to educate as many families as possible toward optimal health through specific Chiropractic care.

Your signature indicates your authorization of "open adjusting":

_____	_____	_____
Name (Printed)	Signature	Date

You may revoke this authorization at anytime.

HUGHES FAMILY CHIROPRACTIC
1039 MARKET STREET
PARKERSBURG, WV 26101

INSURANCE BILLING AGREEMENT

I _____ agree that _____
(Your Name) (Name of Insurance Company)

will be billed for services rendered with Hughes Family Chiropractic. Any balance due is the responsibility of the patient. Any copayment and deductibles are the responsibility of the patient, as well as any non-covered services.

I understand the insurance billing agreement stated above:

Patient's signature_____ Date_____

Witness_____ Date_____

HEALTH QUESTIONNAIRE

Name_____
Date

List all your current health problems:

List any other doctors seen and list treatment received and results obtained:

List all surgeries you have had and list dates:

List any medications you are now taking:

Have you ever been in an automobile accident? When?

Have you ever been in an industrial injury or any other injury for which you received treatment? When?

Please check the conditions you have or have had:

( ) AIDS or HIV	( ) Epilepsy	( ) Polio
( ) Anemia	( ) Hypoglycemia	( ) Rheumatic Fever
( ) Arthritis	( ) Multiple Sclerosis	( ) Tuberculosis
( ) Cancer	( ) Parkinson's Disease	( ) Venereal Disease

FAMILY HISTORY	age	health problems or cause of death
mother:		
father:		
mother's mother:		
mother's father:		
father's mother:		
father's father:		
brothers:		
sisters:		
children:		

Please check (x) all present symptoms

Name: _____

CARDIOVASCULAR
( ) general swelling
( ) swelling in legs
( ) swelling in face
( ) swelling around eyes
( ) chest pain
( ) pounding heart beat
( ) heart "jumps"
( ) rapid heart beat
( ) blue or purple skin
( ) blue or purple nailbeds
( ) fainting
( ) hypertension

VERTEBROBASILAR
( ) double vision
( ) loss of coordinaiton
( ) irregular muscle movement
( ) ringing in ears
( ) heart attack
( ) high blood pressure
( ) irregular heart beat
( ) hardening of the arteries
( ) areas of muscle weakness
( ) dizziness with nausea
( ) dizziness without nausea
( ) blurred vision
( ) fainting spells
( ) stroke
( ) diabetes
( ) pain over the heart
( ) cold hands and /or feet
( ) areas of numbness
( ) arthritis of the neck
( ) previous neck or head injury
( ) loss of memory
( ) inability to form words (talk plainly)
( ) periods of blindness in one eye
( ) areas of abnormal sensations such as burning etc.
( ) areas of numbness
( ) blood vessel disease (phlebitis etc.)
( ) check if you smoke
( ) check if any of your family members have had a stroke.
( ) check if you are taking birth control pills

MUSCULOSKELETAL SYSTEM

HEAD
( ) unusually frequent headache
( ) unusually severe headache
( ) head feels heavy
( ) vertigo
( ) light-headedness
( ) loss of smell
( ) loss of taste
( ) loss of balance
( ) dizziness

NECK
( ) pain in neck
( ) neck pain with movement
( ) swelling in neck
( ) stiff neck
( ) pinched nerve in neck
( ) neck feels out of place
( ) muscle spasms in neck
( ) grinding sounds in neck
( ) popping sounds in neck
( ) limited neck movement

SHOULDERS
( ) pain in shoulders (R-L)
( ) pain across shoulders
( ) tension in shoulders
( ) muscle spasms in shoulders
( ) can't raise arm
  ( ) above shoulder level
  ( ) over head

ARMS & HANDS
( ) pain in upper arm
( ) pain in forearm
( ) pain in hands
( ) pain in fingers
( ) sensation of pins & needles
  ( ) in arms
  ( ) in fingers
( ) fingers go to sleep
( ) hands cold
( ) swollen joints in fingers
( ) sore joints in fingers
( ) loss of grip strength

MID BACK
( ) mid back pain
( ) pain between shoulder blades
( ) sharp stabbing pain
( ) dull ache
( ) pain from front to back
( ) pain over kidney area
( ) muscle spasms in mid back

LOW BACK
( ) low back pain
( ) low back feels out of place
( ) muscle spasms in low back

HIPS, LEGS, & FEET
( ) pain in buttocks
( ) pain down leg
( ) knee pain
( ) leg cramps
( ) pins & needles in legs
( ) numbness in leg
( ) numbness in toes
( ) cold feet
( ) swollen ankles
( ) swollen feet

HEALTH REVIEW

Name: _____

SKIN HAIR NAILS
( ) eczema
( ) itchy skin
( ) dry scalp
( ) oily scalp
( ) rough, scaly skin
( ) dry skin
( ) oily skin
( ) psoriasis
( ) yellow skin
( ) bruise easily
( ) paper thin nails
( ) pale skin
( ) nail biting
( ) baldness

EYES
( ) blurring of vision
( ) double vision
( ) eyes fatique easily
( ) excessive tearing
( ) lack of tearing
( ) light bothers eyes
( ) excessive itching
( ) pain in eyeball

EARS
( ) loss of hearing
( ) pain in ears
( ) discharge from ears
( ) vertigo
( ) ringing in ears

NOSE NASOPHARYNX SINUSES
( ) unusual nasal discharge
( ) nose bleeds
( ) pressure over eyes
( ) pressure under eyes
( ) obstruction of nose
( ) frequent colds
( ) sinusitis
( ) nasal allergies
( ) loss of sense of smell
( ) any trauma to nose

MOUTH AND THROAT
( ) pain in mouth
( ) pain in throat
( ) bleeding gums
( ) cavities
( ) abscessed teeth
( ) dentures
( ) difficulty swallowing
( ) changes in voice

RESPIRATORY
( ) shortness of breath
( ) can't breathe while lying down
( ) can't sleep while lying down
( ) dry cough
( ) productive cough
( ) coughing up blood
( ) wheezing

GASTROINTESTINAL
( ) poor appetite
( ) constant nibbling
( ) difficulty in swallowing
( ) indigestion
( ) can't eat some foods
( ) nausea & vomiting
( ) jaundice
( ) abdominal pain
( ) change in bowel habits
( ) diarrhea
( ) constipation
( ) hemorrhoids

GENITOURINARY
urination is ( ) frequent
( ) normal
( ) infrequent
the amount is ( ) high
( ) normal
( ) low

( ) need to get up at night to urinate
( ) abnormal intense desire to urinate
( ) difficulty starting urination
( ) decreased output
( ) pain on urination
( ) dribbling
( ) blood in urine
( ) cloudy urine
( ) lack of bladder control
( ) abdominal pain

VENEREAL DISEASE
( ) AIDS
( ) syphilis
( ) gonorrhea
( ) other

SOCIAL HISTORY
( ) smoking
( ) other tobacco use
( ) alcohol use
( ) drink coffee or tea

diet is ( ) balanced
( ) not balanced

rest is ( ) sufficient
( ) not sufficient

recreation is ( ) sufficient
( ) not sufficient

my familiy stress is ( ) severe
( ) moderate
( ) minimal
( ) none

how do you like your work?
( ) I like it very much
( ) it's ok
( ) I hate it

my job stress is ( ) severe
( ) moderate
( ) minimal
( ) none

( ) nervousness
( ) irritability
( ) fatigue
( ) depression
( ) generally feel run-down
( ) crave sweets
( ) crave salt

WOMEN ONLY
( ) painful period
( ) spotting
( ) vaginal discharge
( ) premenstural symptoms
( ) irregular periods
( ) lumps in breast

pregnancies _____

of deliveries _____

Hughes
Family Chiropractic
The Very Best In Chiropractic Care For Children And Adults

Anna E. Hughes, D.C.
Family Chiropractor

1039 Market Street
Parkersburg, WV 26101
(304) 428-6900
(304) 428-6973 Fax

RE: HIPAA HAPPENINGS

The Chiropractic Office of Hughes Family Chiropractic.

Patient authorization for contact regarding Chiropractic care, related health services and/or related health products.

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops and products.

The use of this information is intended to make your experience with our office more efficient, productive and to further enhance your access to quality health care.

If you choose not to authorize this information use, your decision will have no adverse effect on your care from Hughes Family Chiropractic or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____	_____	_____
Name (Printed)	**Signature**	**Date**

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.
Thank you!

Hughes Family Chiropractic

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

In the course of your care as a patient at Hughes Family Chiropractic, we may use or disclose personal and health related information about you in the following ways:

* Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

* Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your Employer (if they are or may be responsible for the Payment of your services).

* Your name, address, phone number and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

* If we are providing health care services to you based on the orders of another health care provider.

* If we provide health care services to you in an emergency.

* If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

* If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

* If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive Chiropractic care from us. We may also mail information to you Regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

Hughes Family Chiropractic
1039 Market Street
Parkersburg, WV 26101

If you would like further information about our privacy policies and practices, please contact:

Hughes Family Chiropractic
1039 Market Street
Parkersburg, WV 26101

This notice is effective as of April 14, 2003. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Printed Please)	Signature	Date

If you are a minor or if you are being represented by another party:

_____	_____	_____
Personal Representative (Print)	Personal Representative Signature	Date

_____
Description of the authority to act on behalf of the patient

TERMS OF ACCEPTANCE & CONSENT FOR CARE
HUGHES FAMILY CHIROPRACTIC
1039 Market St, Parkersburg, WV 26101
(304) 428-6900

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of the disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic
or unusual findings, we will advise you. If desire advice, diagnosis or treatment for those findings,
we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

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 complete satisfaction. I therefore accept Chiropractic care on this basis.

_____ _____
(signature) (date)