CRAIG D. COOK, D.C.

PROCARE SPORTS CHIROPRACTIC

PATIENT INFORMATION

PERSONAL INFORMATION

Full Name: _____ Preferred Name: _____

Primary Phone:_____ Address:_____

City: _____ State: _____ Zip: _____ DOB: _____ Age: _____

Occupation:_____ Employer: _____

Have you seen a chiropractor before? Yes ☐ No ☐

PRESENT COMPLAINTS

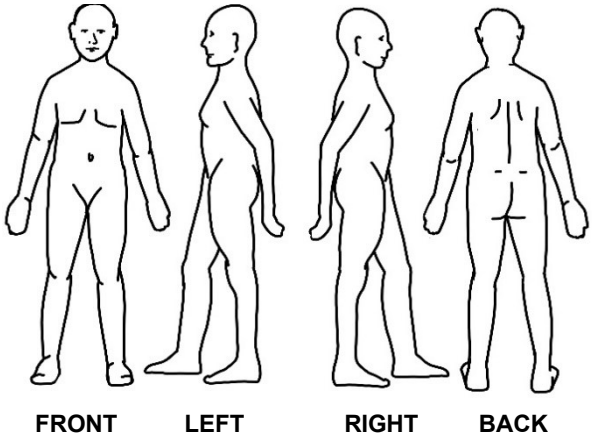
Briefly describe your present symptoms (Please include the date of onset, severity, frequency, etc.):

_____
_____
_____
_____

Other treatment(s) received for these symptoms?

_____
_____
_____
_____

MARK AREAS EXPERIENCING SYMPTOMS



MEDICAL INFORMATION

Medications?: Yes ☐ No ☐ If Yes, please describe: _____

Past Surgeries?: Yes ☐ No ☐ If Yes, please describe: _____

Past Injuries?: Yes ☐ No ☐ If Yes, please describe: _____

I authorize the release of any medical information necessary to process my claims. I also authorize any payments by the insurance company for care in this office to be mailed directly to this office.

Patient's Signature: _____ **Date:** _____

If patient is a minor, signature of Parent or Guardian: _____

Please fill out the following information in case we need to contact you. This information will remain in your chart and will not be accessed by anyone who is not authorized to do so. Thank you.

PATIENT INFORMATION

Patient Name:_____

Home Phone: _____

Cell Phone:_____

Email:_____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship:_____

Phone: _____

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.

The Chiropractic Office is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health information to other health care professionals within our office for the purpose of treatment, payment, or health care operations (Example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with The Chiropractic Office.

"It is our policy to provide a substitute health care provider, authorized by The Chiropractic Office to provide assessment and/or treatment to our patients, without advance notice, in the event of your primary health care provider's absence due to vacation, sickness or other emergency situations."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation

We may disclose your health information as necessary to comply with the State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or other person responsible for your care, about your medical condition in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to Public Health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infectious exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial processing.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners

Organ Donation

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Please Initial: _____

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the General Public.

Specialized Government Agencies

We may disclose your health information for military, National Security, prisoner and government benefits purposes.

Marketing

We may contact you for the following purposes:

Diagnosis, assessment, referral and / or treatment | Payment by a third-party, i.e..: health insurance

Appointment reminders **|** Day-to-day Health Care operations **|** Recall notices

Change of Ownership

In the event that The Chiropractic Office is sold or merged with another organization, your health information / record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that The Chiropractic Office is not required to agree to the Restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have the right to request that The Chiropractic Office amend your protected health information. Please be advised, however, that The Chiropractic Office is not required to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reasons and information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by The Chiropractic Office.
- You have the right to a paper copy of this notice of privacy practices at any time upon request.

Changes to this Notice of Privacy Practices

The Chiropractic Office reserves the right to amend this notice of privacy practices at any time in the future and will make the new Provisions effective for all information that it maintains. Until such amendment is made, The Chiropractic Office is required by law to comply with this notice.

The Chiropractic Office is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Chris Marquardt by calling this office at 760-632-5445. If Chris is not available, you may make an appointment for a personal conference in person or by telephone within 2 business days.

Complaints

Complaints about your privacy rights or how The Chiropractic Office has handled your health information should be directed to Chris by calling this office at 760-632-5445. If Chris is not available, you may make an appointment for a personal conference in person or by telephone within 2 business days.

If you are not satisfied with the manner in which the office handles your complaint you may submit a formal complaint to:

DHHS Office of Civil Rights
200 Independence Avenue, SW
Room 509F HHH Building
Washington, DC 20201

Patient Signature:_____

Patient Name (Print): _____

Date:_____

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PROCARE SPORTS CHIROPRACTIC

INFORMED CONSENT

The Nature of the Chiropractic Adjustment: The primary treatment I use as a doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or mechanical instruments on your body in such a way as to move your joints. That may cause an audible ”pop" or “click”, much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment: As part of the analysis, examination, and treatment, you are consenting to the possibility of the following procedures: spinal manipulative therapy, palpation, range of motion testing, orthopedic testing, basic neurological and muscle strength testing, postural analysis testing, ultrasound, hot/cold therapy, electric muscle stimulation, and/or segmental traction.

The Material Risks Inherent in Chiropractic Adjustments: As with any healthcare procedures, there are certain complications which may arise during Chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care, however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The Probability of Those Risks Occurring: Fractures are rare occurrences and generally results from some underlying weakness of the bone which I check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as an anti-inflammatory, muscle relaxants and painkillers
- Physical Therapy
- Hospitalization
- Surgery

If you choose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The Risks and Dangers of Remaining Untreated: Remaining untreated may allow the formation of adhesions and reduced mobility which may set up a pain reaction, further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW:

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

Date:_____ **Patient’s Name:**_____

Signature of Patient (or Parent or Guardian, if minor): _____