

Dobbs Ferry Chiropractic  
& Holistic Health Center

63 Main Street, Dobbs Ferry, NY  
T: 914.693.4545 / F: 914.231.6672

## PERSONAL HISTORY

Date: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Hme #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Bus #: \_\_\_\_\_ Email: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Business/Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_

Check One:  Married  Single  Widowed  Divorced  Separated No. of Children: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Phone No: \_\_\_\_\_

Referred to this office by: \_\_\_\_\_

Who is responsible for your bill:  Self  Spouse  Workman's Comp.  Medicaid  Medicare

Auto Insurance  Personal Health Insurance  Other: \_\_\_\_\_

## CURRENT HEALTH CONDITION

Purpose of this appointment: \_\_\_\_\_

Other doctors seen for this condition: \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

If disabled from work, please give dates: \_\_\_\_\_

Job related  Auto related

Drugs you know take:  Nerve Pills  Pain Killers/Muscle Relaxers  Blood Pressure Medicine

Insulin  Other: \_\_\_\_\_

## PAST HEALTH HISTORY

Please Check or Describe:

Major Surgery/Operations:  Appendectomy  Tonsillectomy  Gall Bladder  Hernia

Broken Bones  Other: \_\_\_\_\_

Major Accidents or Falls: \_\_\_\_\_

Hospitalization (other than above): \_\_\_\_\_

Previous Chiropractic Care:  None

Doctor's name & approx. date of last visit: \_\_\_\_\_

Have you been treated for any health condition in the last year?  Yes  No

If yes, please explain: \_\_\_\_\_

BELOW IS A LIST OF CONDITIONS WHICH MAY SEEM UNRELATED TO THE PURPOSE OF YOUR APPOINTMENT. HOWEVER, THESE QUESTIONS MUST BE ANSWERED CAREFULLY AS THESE PROBLEMS CAN EFFECT YOUR OVERALL DIAGNOSIS, TREATMENT PLAN AND POSSIBILITY OF BEING ACCEPTED FOR CARE.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Appendicitis    | <input type="checkbox"/> Malaria        | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Alcoholism         |
| <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Venereal Infection |
| <input type="checkbox"/> Diphtheria      | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> Typhoid Fever   | <input type="checkbox"/> Anemia         | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy           |
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Measles        | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Mental Disorder    |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Influenza     | <input type="checkbox"/> Lumbago            |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Small Pox      | <input type="checkbox"/> Pleurisy      | <input type="checkbox"/> Eczema             |

**CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:**

**MUSCULO-SKELETAL CODE**

- |   |   |
|---|---|
| <input type="checkbox"/> Low Back Pain                  | <input type="checkbox"/> Gas/Bloating After Meals |
| <input type="checkbox"/> Pain Between Shoulders         | <input type="checkbox"/> Heartburn                |
| <input type="checkbox"/> Neck Pain                      | <input type="checkbox"/> Black/Bloody Stool       |
| <input type="checkbox"/> Arm Pain                       | <input type="checkbox"/> Colitis                  |
| <input type="checkbox"/> Joint Pain/Stiffness           |   |
| <input type="checkbox"/> Walking Problems               |   |
| <input type="checkbox"/> Difficult Chewing/Clicking jaw |   |

**FEMALES ONLY:**

When was your last period? \_\_\_\_\_  
 Are you pregnant?  Yes  No  Maybe

**NERVOUS SYSTEM CODE**

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities

**GENERAL CODE**

- Allergies
- Loss of sleep
- Fever
- Headaches

**GASTRO-INTESTINAL CODE**

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Trouble
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

**GENITO-URINARY CODE**

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

**C-V-R CODE**

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling

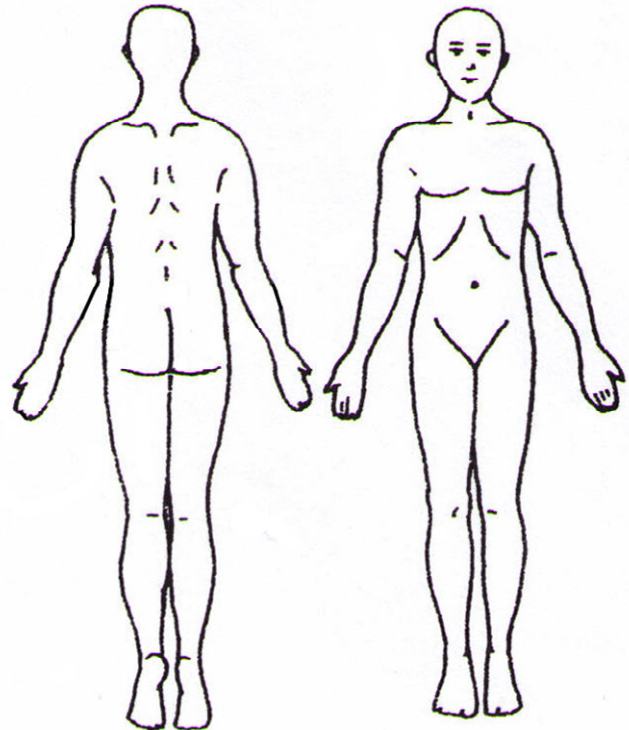
**EENT CODE**

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

**MALE/FEMALE CODE**

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Genital Herpes

**PLEASE OUTLINE ON THE DIAGRAM THE AREA OF YOUR DISCOMFORT**



1 2 3 4 5 6 7 8 9 10

**PLEASE INDICATE THE SEVERITY OF PAIN (10 BEING THE WORST)**

**DO NOT WRITE BELOW THIS LINE**

Diagnosis:

Patient Accepted:  Yes  No

\_\_\_\_\_  
 Doctor's Signature

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). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (Comprehensive Care). Your doctor will weigh your needs and desires when recommending your treatment program.

If this is an accident related injury, please fill out the Accident Form. Thank You!

THE PURPOSE OF OUR CHIROPRACTIC CENTER IS TO SUPPORT EACH INDIVIDUAL IN ACHIEVING THEIR OPTIMUM HEALTH AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND HEALTH AND CHIROPRACTIC AND IN TURN EDUCATE OTHERS.

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. 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 \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's  
Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

**DOBBS FERRY HOLISTIC HEALTH CENTER**  
63 MAIN STREET  
DOBBS FERRY, NY 10522  
(914) 693-4545

Privacy Officer: ALYSSA M. GUGLIELMO, D.C.

Effective Date: APRIL 14, 2003

## **Notice of Privacy Practices**

**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 care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

### **Who Will Follow This Notice**

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

### **How We May Use and Disclose Medical Information About You**

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

**For Treatment.** We may use medical information about you to provide you with medical treatment or services.

Example: in treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party.

Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

**For Health Care Operations.** We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff caring for you.

### **Other Uses or Disclosures That Can Be Made Without Consent or Authorization**

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To worker's compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

## **Uses and Disclosures of Protected Health Information Requiring Your Written Authorization**

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

## **Your Individual Rights Regarding your Medical Information**

**Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

**Right to Request Confidential Communications.** You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend.** If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

**Right to an Accounting of Non-Standard Disclosures.** You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer of this practice.

## **Changes to this Notice**

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.

## NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to patient (if signed by a personal representative of patient):

\_\_\_\_\_

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## MISSED APPOINTMENT POLICY

I \_\_\_\_\_, understand and agree that I am personally responsible for payment for appointments missed without notice in advance, and that it is not the responsibility of the insurance carrier or any third party payer to make payments on my missed appointments.

Missed appointments are billed at \$35/visit.

A photocopy of this form shall be valid as the original.

PATIENT SIGNATURE: \_\_\_\_\_  
(Parent/Guardian if patient is a minor)

DATE SIGNED: \_\_\_\_\_