KAILUA
CHIROPRACTIC
FAMILY WELLNESS

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# HIPAA Consent Form

I give Kailua Chiropractic Family Wellness my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care operations like quality reviews.

I have been informed that I may review the clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand Kailua Chiropractic Family Wellness has the right to change their privacy practices and that I may obtain any revised notices at the clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Kailua Chiropractic Family Wellness is not required to agree to the request. If Kailua Chiropractic Family Wellness agrees to my requested restrictions, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

# Informed Consent

Dear Patient,
Every type of health care is associated with some risk of potential problems. That includes chiropractic health care. We wish you to be informed about the possibility of any potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

# Consent to Treatment

The following points have been explained to me to my satisfaction and I have had the opportunity to discuss them with the doctor and/or other clinic personnel.

1. I understand that the chiropractor will use his/her hand or a mechanical device upon my body to adjust a joint, and there may be an audible “pop” or “click” as result of joint movement.
2. The practice of health care is not an exact science, but relies upon information relayed by the Patient, information gathered during the examinations (and the doctor’s interpretation thereof), as well as the doctor's judgment and expertise. Chiropractic care is no different.
3. It is not reasonable to expect my doctor to anticipate or explain all possible risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgement during the course of any procedures that he/she feels at the time to be in my best interest.
4. Though infrequent, as with any health procedure, there are certain complications that may arise during chiropractic health care. These complications include soreness, sprain/strains, dislocation, fractures, disc injuries, cerebral-vascular accidents, physiotherapy burns, or soft tissue injuries. These complications are extremely rare occurrences.
5. Chiropractic is a system of health care delivery; therefore, as with any other health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will give you our best care.
6. I understand that there are other forms of treatment, including drugs and surgery, which could be treatment options for my condition, but at this time, I choose chiropractic care.

By signing this Confidential Patient Information intake form I acknowledge that I have read the above consent, or it has been read to me. I have had the opportunity to ask questions and receive answers; I am comfortable with the information provided and consent to chiropractic treatment and management on that basis. In signing this document, I in no way compromise my protection against negligence.

_____ _____

Patient or Guardian Date

# Patient Intake Form

First Name: _____ Address: _____
Last Name: _____ City: _____
DOB: _____ State: _____ Zip Code: _____
Sex:_____ Email: _____
Phone 1:_____ Phone 2:_____

Referred By: _____

## Insurance Information

Insurance Company: _____ ID#:_____

## Emergency Contact

Name:_____ Relationship: _____
Phone 1: _____ Phone 2: _____

## Complaint

1. _____ 2. _____

Do you know what caused the problem? _____

On a scale of 1 to 10, with 10 being the worst, please rate your pain: _____

Describe your pain: (Please circle all that apply)

| | | | | |
|---|---|---|---|---|
| Aching | Burning | Cramping | Deep | Dull |
| Numb | Radiating | Sharp | Shooting | Sore |
| Stabbing | Stiff | Swelling | Tight | Tingling |
| Throbbing | | | | |

What makes the problem worse? (Please circle all that apply)

| | | | | |
|---|---|---|---|---|
| Bending | Carrying things | Coughing | Driving | Eating |
| Exercise | Going down stairs | Laying to sitting | Heat | Housework |
| Ice | Jogging | Lifting | Lying down | Massage |
| Most movements | Nothing | Pulling | Pushing | Running |
| Sitting | Sleeping | Sneezing | Squatting | Standing |
| Standing a long time | Stress | Stretching | Taking a deep breath | Turning |
| Twisting | Walking | Working | | |

What makes the problem better? (Please circle all that apply)

| | | | | |
|---|---|---|---|---|
| Nothing | Anti-inflammatories | Bracing | Chiropractic | Elevation |
| Exercise | Heat | Ice | Massage | Movement |
| Pain Killers | Rest | Stretching | Walking | Wraps |

What daily activities are affected by the problem? (Please circle all that apply)

| | | | | |
|---|---|---|---|---|
| Bathing | Caring for children | Cleaning | Climbing stairs | Cooking |
| Doing laundry | Dressing | Driving | Eating | Exercising |
| Sitting to standing | Laying to sitting | Grooming | House Work | Laying down |
| Lifting | Oral Care | Sex | Shopping | Sitting |
| Sleeping | Social activities | Standing | Stretching | Toileting |
| Transferring | Using technology | Using phone | Walking | Watching TV |
| Working | Yard Work | | | |

## Health History

Surgeries:

1. _____ 2. _____

Traumas:

1. _____ 2. _____

Female:

Are you pregnant:_____

Number of pregnancies:_____ Number of deliveries:_____

## Payment and Office Policy

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Kailua Chiropractic Family Wellness all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____ _____

Patient or Guardian Date