WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ 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.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

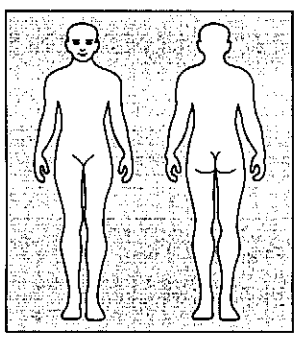
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray _____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No		
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____	
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____
Pharmacy Name_____
Pharmacy Phone (____)_____

ALLERGIES

VITAMINS/HERBS/MINERALS

HIPAA NOTICE OF PRIVACY PRACTICES
LEPIEN CHIROPRACTIC CLINIC
1609 W. PLATO RD., DUNCAN, OK 73533
(580) 252-5800

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical and mental health or condition and related health care services.

I. USES AND DISCLOSURES OF PHI

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

A. Treatment
We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary to a home health agency that provides care to you or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

B. Payment
Your PHI will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your PHI be disclosed to your health plan to obtain approval for the hospital admission.

C. Healthcare Operations
We may use or disclose as needed your PHI to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI as necessary to contact you to remind you of your appointment(s).

We may use or disclose your PHI in the following situations without your authorization, including, as required by law: public health issues; communicable diseases; health oversight; abuse or neglect; Food and Drug Administration (FDA) requirements; legal proceedings; law enforcement; coroners, funeral directors, and organ donation; research; criminal activity; military activity and national security; Workers' Compensation; inmates; required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate to determine our compliance with the requirements of Section 164.500.

D. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

II. YOUR RIGHTS
Following is a statement of your rights with respect to your PHI.

A. You have the right to inspect and copy your PHI. Under Federal Law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or in use of, a civil, criminal, or administrative action or proceeding; PHI that is subject to law that prohibits access to PHI.

B. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI may not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. Your request must state the specific restriction requested and to who you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare provider.

C. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

D. You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal.

E. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this Notice and will inform you of any changes by mail. You then have the right to object or to withdraw as provided in this Notice.

III. COMPLAINTS
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before **April 14, 2003**.

We are required by law to maintain the privacy of and provide individuals with this Notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main telephone number.

Your signature below is only acknowledgment that you have received this Notice of our privacy practices.

Signature_____

Printed name_____

Date_____

LEPIEN CHIROPRACTIC CLINIC
FINANCIAL AGREEMENT

Thank you for choosing Lepien Chiropractic Clinic for your health care needs. When most people enter our office, they are in pain and want a natural approach to relieving it. While our first goal is to help you alleviate your symptoms, our main goal is to assist you in your return to health and ultimately in maintaining a long-term healthy lifestyle.

SERVICES AND SUPPLIES WE OFFER

For your convenience, this office offers the following list of services and supplies, which are not covered under the regular office visit charge:

- Ultrasound
- Interferential (electrotherapy)
- X-rays
- Vitamin and nutritional supplements
- Spinal decompression
- Traction
- Intersegmental traction
- Massage therapy
- Diathermy
- Chair massage
- Pillows
- Biofreeze

All of the above-mentioned treatments and therapies are provided or supplied by our office. If these services are beneficial to your health, Dr. Lepien will recommend them. Our relationship is with you, not your insurance company. We will be happy to file your insurance for you as a courtesy on the day you are treated. For the most part, insurance companies usually do not cover vitamins, pillows, or supplies. In some instances, insurance companies will not cover therapies such as ultrasound or electrotherapy. In those case, payment is due when services are rendered. Any service your insurance does not reimburse us for within 45 days then becomes your personal responsibility.

If you are having financial difficulties, please speak with the Office Manager regarding available methods of payment and to set up a payment plan. Our priority is to get you well. We would not want you to stop your care before we achieve that goal together.

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It has been explained to me throughout my care that I may require some physiologic therapies and/or orthopedic supplies for which I will be responsible. I also understand that I am responsible for any part of my bill not covered by insurance within 45 days of service. I have read and understand the terms stated above.

Signature: ______________________ Date: ______________________
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