



clinica

Beinvenidos a nuestra

Initial Visit Form

GENERAL INFORMATION (all clients fill out)

Informacion del Paciente:

Apellido	nombre	segundo nombre	Fecha de hoy
Domicililo (No PO Box)			Como sabes de nosotros
Ciudad postal	estado	codigo	Numero de seguro social licencia
Telefono de casa	sexo	estate matrimonial	fecha de nacimiento
Telefono de trabajo/ celular	H M	Soltera casado Div. viuda.	Nombre de contacto de emergencia
Correo electronico	Numero de telefono de emergencia		

Informacion de la asecuranca:

Nombre del asgurado	fecha de nacimiento	Fecha que te lastimaste (fecha del accidente)
Tu relacion con el asgurado	Poliza #	Claim # / ID #
Nombre de la compania aseguradora	Que tipo de lastimadura /accidente (escoje uno) trabajo	
Reclamacion al seguro/direccion pare la factura	accidente vehicular	
Ciudad	Estado	Zona postal
otro (explique por favor):		

Historial Medico (all clients fill out)

- Cuando fue tu ultimo examen fisico? _____ Quien te lo hizo ?

_____ no me acuerdo cuando fue mi ultimo examen fisico

- Has tenido un accidente previo/trauma/caidas? **Si/ No/ no me acuerdo** fecha:

_____ Esta problema resultado? **SI/ No (si circulas si , no conteste la #3)**

Si es No, tienes los o similares condiciones? **SI/ No/ no me acuerdo**

Si contesta **SI**, esplique alguna diferencia de intensidad/ frecuencia/ duracion del dolor que sientes actualmente : _____

• Explica cualquier hospitalacion previa: _____ no me acuerdo de hospitalacion previa

• Has tenido cirugias antes? **Si/ No/ no me acuerdo**
Que _____ tipo(s) _____ y _____ la _____ fecha(s)?

• Te has lastimado en trabajo previamente? **SI/ No/ no me acuerdo** fecha: _____

Esta esto resultado? **SI/ No** (*si circula si, ve a la pagina 2: Jefe queja/dolencia*)

Si contesta No, tienes el mismo o similar condicion? **SI/ No/ no me acuerdo**

Si contesta **SI**, explique alguna diferencia de intensidad/frecuencia/duracion del dolor que sientes actualmente: _____

Name: _____ **Date:** _____ **Claim Number:** _____

CHIEF COMPLAINT (all clients fill out)

Notas: Rango 1-10 key: **1-4 = suave, incomodo; 5-7 = angustiante; 8-10 = intenso, insoportable**

- Marca todos lo que aplice. Tu experimentas:

Dolor de cabeza- a donde: dolor cara(784.0) toda la cabeza frente atrás de cabeza ojos temple lado derecho lado izquierdo otros: _____
intensidad: _____ (de _____ 1-10): _____ Comentarios: _____

Dolor cuello- a donde: brota hacia arriba en espalda lado derecho brota hacia arriba en espalda lado izquierdo arriba/abajo mas de lado derecha mas de lado izquierdo irradiar en la cabeza (723.2) dolor cuello(847.0) otros: _____
Intensidad: _____ (de _____ 1-10): _____ Comentarios: _____

Dolor hombro - adonde: lado izquierdo lado derecho los dos lados intensidad: _____ (de _____ 1-10): _____ Comentarios: _____

Dolor espalda media- a donde: toda la espalda media mas el lado derecho mas el lado izquierda

brotar al rededor del pecho radiating a la cabeza(724.4) irradiar a los brazos/piernas
(724.4) otros: _____ Intesidad:(de1-10): _____
Comentarios: _____

Dolor espalda baja-:a donde toda la espalda baja mas al lado derecho mas al
lado izquierdo se dispara al brazos/piernas otros:
Intensidad: _____ (de _____ 1-10): _____ Comentarios:

Dolor Cadera/pelvis -: a donde caderas Pelvico lado izquierda lado derecho
dos lados Intesidad: _____ (de _____ 1-10): _____ Comentarios:

Dolor brazos/piernas-: a donde brazo izquierdo brazos derecho dos brazos pierna
izquierda pierna derecha dos piernas Intesidad: _____ (de _____ 1-10): _____ Comentarios:

Dolor en el Tobillo- a donde: tobillo izquierdo tobillo derecho dos tobillos
Intensidad: _____ (de _____ 1-10): _____ Comentarios:

Otro: _____ - Donde _____ espesificamente:
Intensidad: _____ (de _____ 1-10): _____ Comentarios:

Name: _____ **Date:** _____ **Claim Number:**

• Lista cualquier medicamento que estes tomando y esplica cualquier efecto
secundario: *No aplica* Insulina Cortisona patillas pare nervios
Antidepresibos Shoe lifts
medicamento para presion alta Vitaminas/suplementos
Aspirina- que tan sequido? _____ pastillas para dolor/relajante
de musculo
Algun efectos secundarios :

C.: sientes a dormecidos o cosquillero piernas /pies pierdes tu balance
sientes a dormecidos o cosquillero brazos *no aplica*

- Possible sintomas /dolor de mandivula. Marca los que aplican:
dolor oido, dolor, pica, dolor afilado sonar en el oido mareo problemas
de los dientes cara entumecida rechinas lo dientes en la noche
dolor en articulacione de mandibula o clic sientes tu oido lleno, tapado
otro-explicar por favor:

no aplica

- E. sintoma relacionado con posible cerebro and brainstem. marque todos que a aplica:
- problemas con/largo o corto term memory problemas para concentrarte
agravar/ molestar con ruido ansiedad depresion irritable
problemas para dormir fatiga problemas sexuales
cambio en gusto o oler otros- por favor explicar:

no aplica

- Cuanto tiempo/regularmente tienes o sientes dolor?
todo el tiempo durante el dia durante la noche mas de 6 horas menos
de una hora
in intervals-how long each time?
otro- por favor explique:

- Que hace dolor mejorar ?
aspirina movimiento- a que direccion:
caliente hielo masaje relajante de musculo
descansar expansion descansar en cama elevacion *nada*
otro-por favor explique:

-
- Describi cualquier actividad que haga tus simtomas peor:

-
- Cueando y como empeso el dolor :
-

- J. Describi cualquier informacion adicional sobre tu condicion:

- El accidente / lastimadura en peso el dolor hace mas de dos semanas? **Si / No**
Si es si , por favor explique por que no vino antes de dos semana:

Name: _____ **Date:** _____ **Claim Number:**

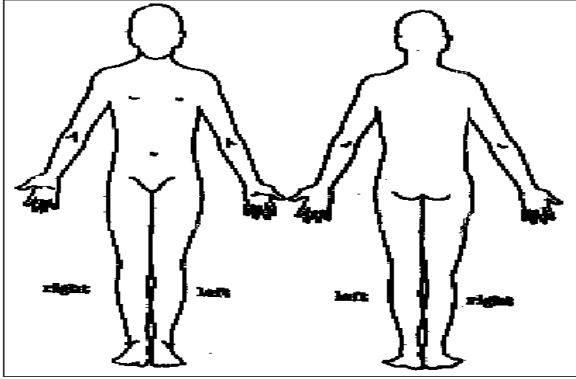
Ensene las areas que siente dolor / siente sensaciones diferente o nousual

Marca la area en este cuerpo donde tu sientes la sensacion describir. Usa los simbolos apropiados. marca la area de radiacion (pain that spreads). Inculle todas las areas afectadas.

entumecido	ardor	Agujas	dolor	doler	apunalar
-----	#####	0000000	x x x x x x	* * * * *	/////////
-----	#####	0000000	x x x x x x	* * * * *	/////////
-----	#####	0000000	x x x x x x	* * * * *	/////////

Por favor marque del cero a 10 la intensidad del dolor que siente con su condicion. 10
peor dolor que ayas sentido con esta condicion

Pain Chart



Dolor cuello-espalda-brazos

On a scale of zero to 10, I rate my Discomfort as follows

(_____)

my

Discomfort as follows

(_____)

dolor severo No • 10 dolor

Dolor espalda media
On a scale of zero to 10, I rate

No dolor 0 10 dolor
severo

Dolor

**Espalda
baja y
piernas**

On a scale of zero to 10, I rate

my

Discomfort as follows
(_____)

10

0

dolor severo

Nodolor

Fecha: _____
X _____

Firma:

SYSTEMS REVIEW

NAME: _____ DATE: _____ CLAIM NUMBER: _____

Por favor revise las siguientes condiciones. Si as tenido alguna condicion en le pasado marque en la columna 1. Si tienes la condicion ahora marque columna 2.

pasado	ahora	GENERAL		pasado	ahora	GASTRO-INTestinal	
		780.6	calen			783	Poco apetito
		780.9	refriedo			536.8	Pobre digestion
		780.8	Sudor noche			994.2	Hambre excesiva
		780.2	desmayarse			787.3	eructar o Gas
		780.4	mareo			787	Nausea
		780.3	Convulsions			787	Vomito
		780.52	Perdida de sueno			578	Vomitanto sangre
		780.7	cansancio			536.8	Dolor sobre estomago
		799.2	nerviosismo			564	estrenido
		783	Perdida de peso			558.9	Diarrea
		782	dolor/miembro entumecido			789	Problema del Colon
		995.3	alergia				sangre en Stool
		786.09	resoplido			455.6	Hemorroides/Piles
		729.2	Neuralgia			785.1	problemas del higado
						782.4	Piel amarilla
						575.98	problemas del vejiga
pasado	ahora	OJOS, OIDOS, NARIZ, GARGANTA		pasado	ahora	SOLAMENTE MUJERES	
		368.9	Pobre vision				
		378.9	Ojos cruzados			786.2	mentruaciones dolorosas

		379.91	Dolor en ojos
		689.9	sordera
		388.7	Dolor de oidos
		388.3	Ruido en oidos
		388.6	oído Discharges
		478.1	Obstruccion nasal
		784.7	Sangrado nariz

		626.2	Flujo excesivo
		626.4	Ciclos Irregulares
		627.2	calores
		625.3	calambre/dolor de espalda
		634.6	aborto
		623.5	Flujo blanco
			embarazo

ultimo Papanicol fecha: _____
 Fecha que comenzo tu ultimo periodo: _____

		462	Garganta adolorida
		784.49	Ronco
		477.9	Fiebre heno
		793.9	Asma
		460	Refriado frecuente
		240.9	Engrosamiento tiroides
		463	amigdalitis
		686.9	Problema senunitis

pasado	ahora	MUSCULO O JOINTS
		debil
		Twitching
		719 hinchado Joints
		781 temblor
		729.5 Problema pies
		724.79 Hueso tail dolorosa
		724.5 Dolor entre hombro
		553.9 Hernia
		Columna vertebral
		737.3 Curvature

pasado	ahora	CARDIO-VASCULAR
		783 Corazon rapido
		427.89 Corazon despacio
		401.9 Presion alta
		458.9 Presion baja
		786.51 Dolor sobre corazon
		438 Problema del corazon
		719.07 Hinchazon en tobillo
		459.9 Mala circulacion
		Vena varicosa
		436 Derrame cerebral

pasado	ahora	PIEL O ALERGIAS
		368.9 erupcion piel
		698.9 picason
		287.8 Moretones facilmente
		701.1 seca
		furunculosis
		782 Piel sencible
		708.9 urticaria/Alergia
		692.9 Eczema

pasado	ahora	GENITALES-URNIARY
		788.3 Orinar frecuentemente
		788.1 Dolor al orinar
		599.7 Sangre en orin
		592 Infeccion en rinon
		788.3 Mojas la cama
		788.1 No control orinar
		601.9 Problema de prostata

SYSTEMS REVIEW

NAME: _____ DATE: _____ CLAIM NUMBER: _____

Name: _____ Date: _____ Claim Number:

Informacion sobre accidente vehicular (MVA clients solamente)

- Fecha del accidente: _____: Numero de carros involucrados en el accidente:

- Auto que estabas: Año: _____ Marca: _____ Modelo: _____
Dano: menor mayor total aprox. \$ _____ valor
- Eras tu el dueno del carro: **Si/ No**
- Otros auto(s): Año: _____ Make: _____ Modelo: _____
- Calle/Interseccion _____ Nombre(s):
Ciudad/Estado: _____
- fue: interseccion luz/signo de para (circule uno) no interseccion
si fue en la luz, estaba: verde rojo amarillo felcha para doblar
la superficie estaba: seco mojado lizo heilo gravilla otro:

- Que tan rapido y en que direccion iba tu carro moviendo cuando pego/pegaron?

- Que tan rapido y en que direction estaba el otro carro moviendo cuando te pego?

- Donde estabas sentado en el vehiculo?
manejador pasajero enfrente pasajero atras izquierda/derecha/centro
(circule uno)
atras en la cama de truca manejador de motocicleta/pasajero (circule uno)
otro-por favor explicar _____ :
- Como estaba tu cuerpo posicionado al tiempo del accidente?

mirando hacia abajo asiendo algo mas mirando al trafico viniendo
mirando al pasajero mirando a enfrente
doblar a la izquierda/derecha (circular uno) mirando a traffico oncoming
mirando por el espejo rear view mirando al manejador
otro-por favor explique:

- En que areas de tu carro le pegaron ?
enfrente lado de la esquina manejador esquina trasera al lado manejador lado del manejador
enfrente esquina pasajero esquina trasera del pasajero lado pasajero
defense delantera defense trasera trasera trailer
collision de frente total otro: _____

- habia otro secundo impacto? **Si/ No** Si, a donde fue el impacto en tu carro?

- Mi cuerpo pego el volante respaldo
paneles de al lado asiento con mi pecho/abdomen/cabeza/cara (circulo uno) tablero
puerta atras del asiento del manejador
pavimento
consolar otro-por favor explique:

Name: _____ **Date:** _____ **Claim Number:** _____

- Las siguientes parte de mi cuerpo fueron golpeadas: cara frente nariz cuello
hombro brazo mano muñeca dedos pello abdomen cadera muslo rodilla shin
otro- Por favor explique: _____

- Descripcion adicional del accidente:

- Huvo un aviso antes del impacto?**Si/ No**
- Se desplego la bolsa de aire?**Si/ No**
- Tiene tu carro respaldor? **Si/ No**

- Como resultado del accidente estuviste: indefenso/incosciente aturdido no puedes mover ciertos partes del cuerpo-por favor explique que partes y porque:

moreton o sangrar (Porfavor describer lesion):

conmocionado pero puedo funcionar si pudo parar/fuera del carro y caminar no muy preciso sobre lo que sucedio

- Si te acuerdas haberte golpeado la cabeza? no me acuerdo de haberme golpearme la cabeza

Si, me acuerdo de golpearme la cabeza No, me golpie la cabeza

Siquiendo el accidente:

- Estaba el personal de emergencias en la escena? **Si/ No**
- Te llevaron a el hospital cuarto/ habitacion de emergencias? **Si/ No**
Si, nombre del hospital: _____ Que areas te comprobar/trataron?

- Tu hiciste seguimiento con el tratamiento para tus heridas? **Si/ No**
Si _____, en _____ cual _____ hospital?

- Te tomaron rayos x?**Si/ No** Si, que parte del cuerpo?

Por quien? _____

Tu reportaste el accidente con tu compania de seguro? **Si No**

- Tu tienes un abogado que te represente por este accidente ? **Si No**
Si, por favor proporcionar los siguientes para nuestro registros:
Nombre del abogado: _____ telefono #

Direccion del abogado:

ciudad/estado/zona postal :

Name: _____ **Date:** _____ **Claim Number:**

Consentimiento para tratar & Acuerdo financiero (por favor leer y firmar)

Yo comprendo completamente que Yo soy reponsable directamente/completamente por todos los cargos la clinica, contraer por servicios hechos a mi, y que este arreglo esta hecho unicamente para proteccion de la clinica I en consideracion contingete de cualquier resolucio, fallo o veredicto por cual yo pueda finalment recuperar. Yo soy la persona responsable por la factura, a pesar de cualquier resultado de reclamo/causa legal.

Yo autorizo a mi compania de seguro que hago pagos directamente a esta oficina. El doctor no es responsable por niguna condicion medica diagnosticada pre-existente.

Nosotros llamaremos para verificar elegibilidad y benefios como cortesia a nuestros pacientes. Con la poliza del seguro es un contrato entre el patient y la compania de seguro, Nosotros no podemos garantizar estos benefios. Cualquier cantidad que la compania de seguro no cobra pasara hacia la responsabilidad de el paciente, a pesar de todo de alguna reduccion, negacion o arbitraje. Determinacion de honorarios habitual /acostumbrado. Nosotros aconsejamos/ asesoral nuestros pacientes que verifique su propio seguro.

En orden para tener privilegio/honor para facturar el seguro prorrogada a mi, Yo entiendo que yo tengo que: reportar mi accidente ala compania de seguro de auto a la oficina de reclamos y proporcionar a la compania de seguro de auto con toda la solicitud necesaria PIP (Personal Injury Protection) (personal lesion y proteccion).

Yo e leido, comprendido, y estoy de acuerdo con el contrato sobre finansamiento declarado arriba.

fecha _____ **X** firma de los padres, //guardian legal para pacientes menores de 18 años _____

fecha _____ firma del testico _____



IRREVOCABLE DOCTOR'S LEIN
AND ASSIGNMENT OF RIGHT TO RECOVERY

Name: _____ Date: _____ Claim Number: _____

En consideracion y intercambio para que no tengas que pagar tu deuda inmediatamente y en consideracion recidiras en el futuro cuidado en o por la clinica y el doctor en de quien de quien letterhead en este document esta imprimido (hereinafter "clinica"), Yo, el lo abajo firmante, por esto asignar y transmitir a la clinica un legal y equitable interesen cualquier y todas la causa de accion o derechos de recuperacion yo puedo haber surgido/presentarse fuera de ese cierto accidente o lesion-producir/ fabricarze acontecimiento que ocurra/sucede en o sobre _____, a la lleno alcance de el costo y tratamiento proporcionado o va hacer proporcionado a mi por la clinica.

Yo como resultado de esto autorizo y directo a mi abogado(s) con toda confiansa, y que page directamente a la clinica la suma,cantidad que se deba a la clinica por tratamiento y otros servicio professional prestados mi las dos por la razon de el accidente y por razon de cualquier otras factures que se le dedan a la clinica y de retener tal suma desde cualquier ver,conceder y transportar a otra persona con mi caso a la clinica contra cualquier y todo lo recaudado de cualquier y todo causade accion, resolucion, fallo o veredicto cual se pueda pagar a o a traves de mi abogado, or yo mismo, como resultado de mi lesion o condicion por la cual e ver tratado por la clinica .

Si no abogado puede ser confiado con mi caso , Yo entiendo/comprendo que el seguro le pagara directamente a la clinica por todos los servicios prestados como resultado de este accidente y o cualquier otra factura que se deba.

Yo comprendo completamente que yo soy directamente y completamente responsable a la clinica por todas las facturas contraer por servicios prestados a mi y que el acuerdo esta hecho unicamente por la clinica para protection adicional y en consideracion contingente en cualquier resolucion,fallo o veredicto por que yo pueda finalmente recuperar. Yo soy personalmente responsable por mi factura, a pesar de todo i del cualquier resultado,afirmacion legal o causa.

Yo comprendo completamente que si mi abogado(s) si o no protégé los interes de la clinica, la clinica puede requerirme a mi que haga pagos en mi cuenta. La clinica tambien puede traer provocar accion contra mi abogado(s) por fallar a honrar este vinculo y irrevocable trato entre mi y la clinica

Yo ademas comprendo y estoy de acuerdo que la clinica no es responsable por el honorarios de mi abogado y la clinica no esta de acuerdo en pagar los honorarios del abogado por honor acuerdo entre yo y la clinica.

“I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY(S) TO PROTECT THE CLINIC’S AND DOCTOR’S INTEREST AT TIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHTS TO THE CLINIC. I ALSO KNOW I MAY NOT REVOKE THIS AGREEMENT AT ANY TIME WITHOUT PRIOR WRITTEN AUTHORIZATION FROM THE CLINIC. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT AND LEIN.

X _____

Imprimir Nombre paciente

Firma del paciente

Fecha

Imprimir Nombre abogado /
Fecha

Firma del Abogado/ Ajustador

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION-RECORDS

Last name:	MI:	First Name:		
Home Address:	City:	State:	Zip:	
Date of Birth:	Social Security/ID Number:			

The 1996 Health Insurance Portability and Accountability Act (HIPAA) require that all health care providers comply with the patient privacy and security laws (45 CFR Parts 160, 164). Patient confidentiality and privacy/security applies to any protected health information (PHI) contained within the medical records. Federal Law now require signed and dated authorization from patients in several aspects of patient care, transmission of medical information, confidentiality, and patient rights relating to their release of medical records.

LIST PURPOSE(S) FOR WHICH THE INFORMATION IS NEEDED:

AUTHORIZATION EXPIRATION. Without my express revocation, this authorization will expire 12 months from the date signed: (1) upon satisfaction of the need for disclosure; (2) on date (supplied by patient) _____; (3) under the following conditions (examples: case closure, termination of plan benefits, ECT)

RELEASE AUTHORIZATIONS (Patient, please initial the following section(s) that apply to you.

_____ **Initial.** Doctor/Medical Facility... I authorize release of entire set of my medical records including: intake forms, history, diagnosis, treatment, consultation, neurological/laboratory/radiologic scan or test results, disabilities, billing information, reports, correspondence, and medical records from other sources to the following doctor/facility/person:

List Name/Address: _____

_____ **Initial. Insurance-Medical Plans.** I authorize said doctor to communicate with, send updated billing, reports, and release all medical records necessary to process this claim to the following insurance companies and/ or governmental agencies listed below:

List: _____

_____ **Initial. Attorney.** I authorize said doctor to communicate with my retained attorney (paper, electronic, and oral). I further authorize the release of reports, all medical and treatment records, billing records photos, and other records necessary to process my claim. This authorization is valid until the case is closed or at the conclusion of litigation and said doctors bills have been fully paid.

Name of attorney: _____, Date of Injury: _____

_____ **Initial. Family/ Friend.** I authorize said doctor to communicate with the following friend/family member about my health condition and recommendations. Name of person(s): _____

_____ **Initial** Yes, No: **[Special Limitations for Release of Sensitive Protected Health Information.]** I specifically authorize the release of HIV/AIDS test results, sexually transmitted or communicable disease notes (such as Hepatitis or venereal diseases), drug, alcohol, or substance abuse or treatment notes, behavioral, mental health disabilities or developmental disability, (including mental retardation), abuse, neglect or domestic violence, sickle cell anemia, government research, or genetic testing information. The recipient is prohibited from redisclosing such sensitive PHI information without my authorization unless permitted by state and Federal law. List any other special restrictions that you want limited (e.g., psychiatric/psychological records):

AUTHORIZATION

- I certify that this request has been made freely, voluntarily and without coercion and that the information is accurate.
- I voluntarily authorize and request that my health information (including paper, oral, and electronic interchange) be release to the above sources as set forth on this form.
- I can revoke this authorization at any time by giving my written revocation in writing to said doctor’s office. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this authorization
- The disclosing health care provider/plan/may NOT condition treatment, enrollment in the health plan or eligibility for benefits on whether I sign this authorization.
- Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal and state law.
- I have the right to request a list of doctors, facilities, and/or government agencies which have been sent my medical records.

X
(Date) _____ (Signature of Patient)

(Date) _____ (Signature of person authorized by law)

REQUEST FOR MEDICAL RECORDS

PATIENT NAME: _____ DATE: _____

Patient Identification:	Social security: Medical record No:	Date of Birth:
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Request Records From (Name and address of Doctor/ Facility where patient’s medical records are presently located):

Name:	
Address:	

SEND THE SPECIFIED AND AUTHORIZED MEDICAL RECORDS TO:

Doctor's Name:	Dr. Albert Noble D.C. Enterprise Chiropractic Clinic
Address:	10576 SE Washington St, Portland, OR, 97213
Telephone:	503-252-5320

WHAT MEDICAL RECORDS ARE AUTHORIZED TO DISCLOSE AND MAIL:

- All Medical Records
- X-Ray/MRI/CT reports
- EMG, SSEP, Nerve Conduction, Laboratory tests, Diagnostic Test Report.
- Other

SPECIFIC DATES AUTHORIZED FOR RECORDS RELEASE

Medical records from (insert date) _____ to (insert date) _____

PURPOSE OF RELEASE OF INFORMATION

- At request of above patient
- Other:

I hereby request and authorize disclosure of the above protected health information in my medical records kept at your office or facility to be photocopied, released and mailed to above doctor/facility at the indicated address for the specified dates. I understand that the Health Insurance Portability and Accountability Act (HIPAA) apply to my medical records and protected health information. I expect the holder of my medical records to mail my specified medical records as soon as reasonably possible, not to exceed 30 days if kept on-site, and 60 days if stored off-site, once this request has been received. This authorization may be revoked by me, at any time, by advising the doctor's office (privacy officer) of this revocation in writing, except to the extent a source of information has already relied on it. I have been advised that if I choose to not sign this authorization that it will not have any adverse effect on my treatment, eligibility for benefits, enrollment, or payment.

EXPIRES: This authorization is good for 12 months from the date signed for the disclosure of the information described above.

*This authorization does not apply to any record/notes regarding HIV/AIDS, communicable disease, alcohol or drug treatment, mental health information, behavioral health care, domestic violence, genetic testing, and psychiatric or psychotherapy notes.

PATIENT NAME (Print clearly): _____

INDIVIDUAL AUTHORIZING DISCLOSURE (Signature): _____ DATE: _____

If not signed by patient, specify basis for your authority to sign: Parent of minor, Guardian

This general and specific authorization to disclose was developed to comply with the provisions regarding disclosure of medical information under HIPAA: 45 CFR Parts 160 and 164, 42 CFR part 2, 38 CFR parts 99 and 300, and State Law.

ENTERPRISE CHIROPRACTIC

NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU
MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS
INFORMATION.**

PLEASE REVIEW IT CAREFULLY

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of Our Privacy Practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of **04/15/03**, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the Privacy Practices described below at any time in accordance with applicable law. Prior to making significant changes to our Privacy Practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you upon request. Any changes we make to our Privacy Practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our Privacy Practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. TREATMENT, PAYMENT, and HEALTH CARE OPERATIONS: You should be aware that during the course of our relationship with you, we will likely use and disclose health information about you for treatment, payment, and health care operations.

Examples of these activities are as follows:

- Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
- Payment: We may use and disclose your health information to obtain payment for services we provide to you.

- Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare Operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

B. **AUTHORIZATIONS**: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

Name: _____ **Date:** _____ **Claim Number:**

C. **DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES**: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

D. **MARKETING**: We will not use your health information for marketing communications without your written authorization.

E. **USES OR DISCLOSURES REQUIRED BY LAW**: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are the possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. **PATIENT AND THIRD PARTY PROTECTION**: Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

G. LAW ENFORCEMENT / NATIONAL SECURITY: Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities.

H. APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

- **ACCESS TO RECORDS:** Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we will charge you \$0.25 for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

Name: _____ **Date:** _____ **Claim Number:**

B. ACCOUNTING OF CERTAIN DISCLOSURES: Upon written request, you have the right to receive a list of instances in which we, or our business associates, disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before **April 14, 2003**. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right

to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions, we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

D. AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. ELECTRONIC NOTICES: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form as well.

QUESTIONS AND COMPLAINTS:

If you want more information about our Privacy Practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decision we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

CONTACT: Dr. Albert Noble, Enterprise Chiropractic Clinic
FAX: 503-639-2052
E-MAIL: info@drnoble.net

MOTOR VEHICLE COLLISION GENERAL PRECAUTIONS AND INSTRUCTIONS

PATIENT: _____ **DATE** _____

Strong and very rapid forces may be involved in your automobile accident. It is important that you watch for any new symptoms that might be a sign of hidden injury and/or increased inflammation. It is normal to feel soreness, pain, and tightness in your body, often getting worse the second or third days. However, more severe pain and new symptoms such as numbness, tingling, balance issues, and weakness in your arms and legs should be reported to your doctor as soon as possible. Although you may have a lot of soreness, stiffness, and/or pain, most people recover over time.

As a result of a motor vehicle collision, some people feel a general sense of stress or anxiety which can lead to trouble sleeping or irritability. Some people feel like avoiding driving in vehicles for some time. In the majority of cases, these feelings go away within a few days or weeks.

AVOID NEW INJURIES

It is important for the first week or two weeks to avoid any high-risk physical activities or contact sports that may re-injure you and cause new injuries. Avoid excessive jarring activities or extreme physical activities, such as heavy lifting.

HOME CARE

It is important to comply with the home recommendations that the doctor gives you. Your doctor will be giving you advice about how important it is to keep physically active during the healing process.

- Do not sit-up in bed watching TV or reading or sit on soft couches. Firmer chairs are advised.
- Avoid twisted positions with your neck and back
- Lie on the floor or bed with your legs and knees bent with a pillow under your knees to reduce back pain
- Change your body position every 30 minutes for the next week
- Do slow and gentle stretches 4-6 times a day for 1-2 minutes. Do not push into moderate or severe pain. Stretches can include sitting shoulder rolls, lying on the floor and gently holding each knee to the chest, and general flexibility motions for the neck and back. As you feel better the stretches can be increased.
- Take short walks every day (start with level surface) for 5-10 minutes and repeat 3-4 times each day. Work up to longer walking periods and gradually increase your walking speed and time. The goal is to get you walking an hour a day. Once you feel better then you can walk up hills.
- Avoid sitting/standing or any awkward positions for prolonged periods for the next two weeks.
- Use good posture and proper body mechanics over the next few weeks.
- Getting an extra 30-60 minutes of extra sleep a night is recommended for the first week. Make certain to get restful sleep.
- Use ice for the 3-4 days. Place a thin towel between the ice pack and your skin and keep the ice on for the prescribed length of time. Do not fall asleep with ice pack on. Neck use ice for 10-15 minutes and the back use 20-30 minutes.
-

GOALS OF THIS OFFICE

The primary goal of this office is to restore your ability to return to your normal pre-injury physical activities of daily living; including work, home, sports, and recreational activities. Our office focuses on improving joint and soft-tissue function by providing appropriate therapies to injured areas and thus assisting your body in healing and reducing pain levels and aiding your recovery. Your active participation at home and work is important in the recovery process and your compliance with the appointments and exercise recommendations will improve your outcome.

MONITORING YOUR PROGRESS IS IMPORTANT TO OUR OFFICE

Our office staff will periodically ask you to fill out additional paperwork that is designed to document your response to spinal manipulation and other therapies/procedures and your responses allow our office to determine if your treatment outcome is on track, if your treatment needs to be changed or modified, if further testing is indicated, if a consultation by another health care provider is needed, or if a referral is indicated.

FOLLOW-UP APPOINTMENTS

It is important that you keep all of your appointments and follow all home instructions, including exercise, stretching, use of ice, and watching your posture. Call your doctor if you have any problems. If you miss or do not show-up for two appointments, our office will need to talk to you about your absence and find some way to work with your schedule. If four scheduled appointments are missed the office may refer you to another provider, depending upon circumstances.

Name: _____ Date: _____ Claim Number: _____

DYANOMETER LECTURA

<u>Mano izquierda</u>	<u>Mano derecha</u>
1.) _____ _____	1.) _____
2.) _____ _____	2.) _____
3.) _____ _____	3.) _____

Promedio para la mano izquierda:
Promedio para la mano derecha :

PHYSICAL EXAMINATION

Altura: _____ Peso: _____ B.P. ____/____ Pulso: _____

Fecha de llamada:
EMPLEADO:

ECC VERIFICAR NOMBRE DEL

MVA PIP Coverage Questions:

Is this a third party insurance or is this the patient's personal insurance? Third party _____ Personal _____ (Third Party is only accepted if the injured is not at fault, but has no personal insurance)

*If you answered **third party** to the above question; did the other insurance company accept liability? _____*

If third party, you must send the signed Doctor's Lien to the adjuster (or lawyer if they have one) and have them sign it and send it back to us

Nombre del paciente : _____

Fecha de nacimiento: _____

Fecha de la lesion: _____

Hablates con: _____

Numero de reclamacion: _____

Numero de poliza (Opcional): _____

PIP Adjuster Name: _____

Numero de telefono w/ext.: _____

Numero de fax: _____

Medical PIP disponible y esta abierto? _____

A que direccion nosotros mandamos/enviamos la factura? _____

Yo verifique y contacte la compania de seguro en la fecha:

±

Firma:

±

*Grupo de gente en el mismo carro juntos so you can ask all the questions on the same phone call.

*PIP coverage is through your own insurance no matter who is at fault in the ac