

First Visit Date: _____

Patient Information

The BodyMind Center at Thompson Health, 350 Parrish Street, Canandaigua, NY 14424 (585) 396-6679

Patient to complete the following sections:							
Patient Last Name		First Name		MI	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Age	Date of Birth
Patient Address			City		State		Zip Code
Home Phone #		Work Phone #			Height		Weight
In case of emergency contact:		Marital Status <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> W		# of Children		Social Security #	
Referred By:		Previous chiropractic care? <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient Email: <i>(Always Kept Private)</i>			
Insurance Information:							
Insured Last Name		First Name		MI	Insurance ID #		Date of Birth
Employer				Insurance Company Name			
Is illness or injury related to: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other		Do you have secondary insurance that might cover this injury/illness: <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, other insurance company name:		
Primary Care Physician Information:							
Doctor's Last Name		First Name		Have you seen your primary doctor for this complaint? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____			
Address		City		State	Zip Code	Phone Number	

History of Injury or Current Complaint:

Please briefly describe your injury or current complaint and date of onset: _____

When does your complaint feel worse? AM PM Please explain: _____

Does your pain interrupt your sleep? No Yes Please explain: _____

What activity is affected most due to this complaint? _____

Previous Conditions and Treatment:

Please briefly list any previous medical conditions and treatment: _____

List all medications and supplements: _____

Do you have any allergies NO YES Please explain: _____

List all dates of hospital visits and/or types of surgeries: _____

Are any of these conditions in your family history? Autoimmune disorders Cancer GI disorders
 Heart disease Neurological Arthritis Diabetes Kidney disease Seizures

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature _____ Today's date: ____/____/____

If patient required assistance to complete this form, sign your name and state relationship (i.e.,parent, translator)

Name _____ Relationship _____ Today's date: ____/____/____



Name: _____ Date: _____

INSTRUCTIONS: Please circle the number that best describes the question being asked. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

1. What is your pain RIGHT NOW?

no pain

0 1 2 3 4 5 6 7 8 9 10

worst possible pain

2. What is your TYPICAL or AVERAGE pain?

no pain

0 1 2 3 4 5 6 7 8 9 10

worst possible pain

3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

no pain

0 1 2 3 4 5 6 7 8 9 10

worst possible pain

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

no pain

0 1 2 3 4 5 6 7 8 9 10

worst possible pain

For doctor to fill out:

Score: #1 _____ + #2 _____ + #4 _____ = _____ /3 x10= _____ (Low intensity = <50; High intensity = >50)

Comments:

Patient Initials: _____ Doctor's Initials: _____

PAIN DIAGRAM

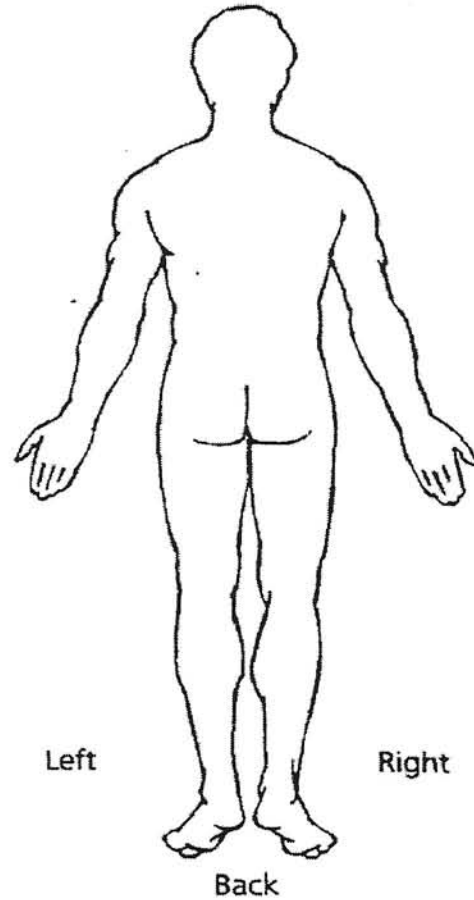
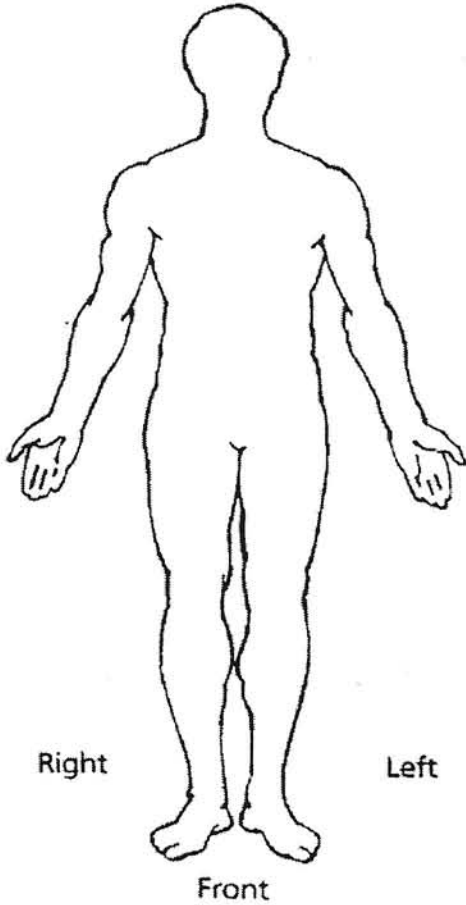
Aching
 ▲ ▲ ▲

Numbness
 = = =

Pins and needles
 ○ ○ ○

Burning
 × × ×

Stabbing
 / / /



Place an 'X' at the place that represents your level of pain today.

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

 Patient Signature

 Date

**The BodyMind Center
360 Parrish Street, 1st Floor
Canandaigua, NY 14464
(585) 369-6679**

**NOTICE OF PRIVACY PRACTICES
(MEDICAL)**

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 Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information.

We may use and disclosed your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14th, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint write to The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 (202) 619-696-6775
Toll Free: 1-877-696-6775

Acknowledgement of Receipt of Notice of Privacy Practices

Please sign and print your name and provide the date below to acknowledge that you have received, read, and understand our Notice of Privacy Practices. Please return it to our front office staff at your next visit or mail it to The BodyMind Center, 360 Parrish Street, Canandaigua, NY 14424.

Patient Name: _____

Relation to Patient: _____

Signature: _____ Date: _____

CONSENT FOR TREATMENT

I, (or _____ acting on behalf of) _____
(Patient Representative) (Patient)
suffering from a condition requiring hospital care, hereby consent to the rendering of such care, which may include routine diagnostic procedures and such medical treatment as my attending physician or others of the hospital medical staff consider to be necessary. Absent emergency or extraordinary circumstances, if further consent for test(s) or treatment(s) is necessary, and warranted by my condition, the procedure(s) will be explained to me by the physician or his/her representative as appropriate, and further consent sought from me at that time.

I hereby acknowledge the right to consent or refuse any proposed procedure(s) or treatment(s). This consent has been fully explained to me and I am satisfied that I understand its content and significance.

(Patient Signature) (Date) (Hospital Witness) (Date)

Patient is a minor or is unable to consent because _____

(Legal Guardian or Closest Relative) (Date) (Hospital Witness) (Date)

PERSONAL PROPERTY STATEMENT

F.F. THOMPSON HOSPITAL cannot be responsible for any clothing, personal articles such as dentures, valuables including money, radio or the like, kept at your bedside. For safekeeping, send as much as possible home with your family. If necessary, valuables may be kept in our safe and released Monday-Friday from 8:00a.m. -4:30p.m. I hereby certify that I have read and fully understand the above statement.

PATIENT FINANCIAL INFORMATION/ASSIGNMENT/MEDICAL RELEASE/GUARANTEE OF ACCOUNT

I understand that total payment of all charges is due upon discharge, with the allowance made for insurance coverage approved before discharge, unless the F.F. THOMPSON HOSPITAL agrees otherwise in writing. By signing this form, I agree to pay at the time of discharge for all services given to the above patient. I understand and agree that I am financially liable for all hospital charges not paid by third party benefits. Should I fail to pay the amount owed and you hire an attorney/collection agency to collect what I owe, I will pay the reasonable court costs, and fees you incur.

I hereby assign, transfer and set over the F.F. THOMPSON HOSPITAL sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

In consideration of F.F. THOMPSON HOSPITAL furnishing services for the captioned patient, I hereby guarantee and promise to pay the hospital all charges for services furnished or rendered to this patient while he or she shall remain a patient of the hospital. Should I fail to pay the amount owed and you hire an attorney/collection agency to collect what I owe, I will pay the reasonable court costs, and fees you incur.

I have received Thompson Health's Notice of Privacy Practices: _____

(Signature of Patient) or (Responsible Party: Minor's Parent or Legal Guardian) (Date)

(Guarantor's Signature) (Relationship) (Date)

(Witness Signature) (Date)

