



## New Patient Information

Please print

Date \_\_\_\_\_

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

City, State, Zip \_\_\_\_\_ Cell Phone# \_\_\_\_\_ Home Phone# \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_ No of Children \_\_\_\_\_

Marital Status – M S D W Spouse's Name \_\_\_\_\_ Email Address \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ PCP Phone# \_\_\_\_\_ PCP Address \_\_\_\_\_

Would you like us to send a brief report or update to your Primary Care doctor? Y \_\_\_ N \_\_\_

Your Occupation \_\_\_\_\_ Employed by \_\_\_\_\_ Wk Phone# \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Have you ever had chiropractic care before? Y \_\_\_ N \_\_\_ If so, when? \_\_\_\_\_

List your chief complaints in order of severity:

1. \_\_\_\_\_ For how long? \_\_\_\_\_ 2. \_\_\_\_\_ For how long? \_\_\_\_\_

3. \_\_\_\_\_ For how long? \_\_\_\_\_ 4. \_\_\_\_\_ For how long? \_\_\_\_\_

List other doctors consulted for these conditions:

1. \_\_\_\_\_ Address \_\_\_\_\_

2. \_\_\_\_\_ Address \_\_\_\_\_

Is this injury or illness work-related? Y \_\_\_ N \_\_\_ Have you reported it to your employer? \_\_\_\_\_

Is this injury or illness related to an automobile accident? Y \_\_\_ N \_\_\_ If yes, please complete the following:

Auto Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

Address \_\_\_\_\_

Agent's Name \_\_\_\_\_ Agent's Phone # \_\_\_\_\_

**NOTICE: Not all patients require X-rays to determine or verify a diagnosis, type of treatment or length of treatment; if your examination warrants X-ray analysis, the following office policy prevails:**

**(1) All first visit charges with or without X-rays are payable when service is rendered.**

**(2) The fee paid for treatment X-ray is for analysis only. The film itself is the property of this office and remains part of your permanent record.**

Method of payment you plan to use for today's visit:

Check  Cash  MasterCard  Visa

Major Medical Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_ ID# \_\_\_\_\_

Other Health Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_ ID# \_\_\_\_\_

Medicare \_\_\_\_\_ Medicare # \_\_\_\_\_

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

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

**Surgery (Please include all surgery)**

(1) Type \_\_\_\_\_

When \_\_\_\_\_

(2) Type \_\_\_\_\_

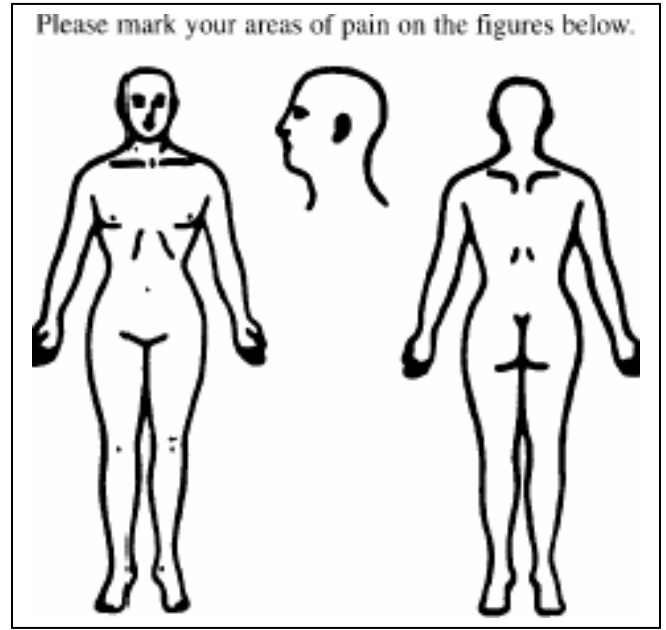
When \_\_\_\_\_

(3) Type \_\_\_\_\_

When \_\_\_\_\_

**ARE YOU NOW OR HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING:**

- Stroke
- Fatigue
- Migraine
- Nervousness
- Arthritis
- Heart disease
- Headache
- Shingles
- Dizziness
- Stiff neck
- Swollen joints
- Pregnant at this time
- Numbness or pain in arms/legs/hands
- Pain between shoulders
- Spinal curvature
- High blood pressure
- Heart Attack
- Cancer
- Diabetes
- Sinus
- Backache
- Stomach



**0 ————— 5 ————— 10**

Please rate your pain: 0 Absent to 10 Extreme \_\_\_\_\_

Are symptoms:  Getting worse  Getting better  Staying the same

How often do your symptoms occur?

Occasional (0–25%) \_\_\_\_\_ Intermittent (25– 50%) \_\_\_\_\_ Frequent (50– 75%) \_\_\_\_\_ Constant (75– 100%) \_\_\_\_\_

How would you describe your symptoms? Ache \_\_\_\_\_ Burning \_\_\_\_\_ Dull \_\_\_\_\_ Sharp \_\_\_\_\_ Stabbing \_\_\_\_\_ Other \_\_\_\_\_

When are your symptoms worst? Morning \_\_\_\_\_ Afternoon \_\_\_\_\_ Evening \_\_\_\_\_

Do your symptoms wake you up at night? Yes \_\_\_\_\_ No \_\_\_\_\_

Are your symptoms aggravated by: Coughing \_\_\_\_\_ Sneezing \_\_\_\_\_ Movement \_\_\_\_\_ Straining to stool \_\_\_\_\_ Lifting \_\_\_\_\_

Bending \_\_\_\_\_ Sitting \_\_\_\_\_ Standing \_\_\_\_\_ Other \_\_\_\_\_

Are your symptoms relieved by: Nothing \_\_\_\_\_ Rest \_\_\_\_\_ Ice \_\_\_\_\_ Heat \_\_\_\_\_ Stretching \_\_\_\_\_

Exercise \_\_\_\_\_ Sitting \_\_\_\_\_ Standing \_\_\_\_\_ Other \_\_\_\_\_

Do your symptoms remain local? Y N

Do your symptoms radiate? Y N Left leg \_\_\_\_\_ Right leg \_\_\_\_\_ Left arm \_\_\_\_\_ Right arm \_\_\_\_\_ Back of head \_\_\_\_\_ Other \_\_\_\_\_

How long has pain been present? \_\_\_\_\_

How did the pain begin?  Gradual  Sudden

Please explain: \_\_\_\_\_

\_\_\_\_\_

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

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

**X-RAY CONFIRMATION:** This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to spinographic pictures.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT TO TREAT A MINOR CHILD:** I hereby authorize this office to administer chiropractic as deemed necessary for my child.

Signature \_\_\_\_\_ Parent/Legal Guardian Date \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION**

To: Activator Health Center

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

**Medicare Patients**

I request that payment of authorized Medicare benefits be made to me or on my behalf to Activator Health Center for any services furnished to me by Arlan Fuhr, D.C. and/or David Iacune, D.C. I authorize that any holder of medical records about me to release to the Health Care Financing Administration and its agents any information necessary to determine benefits and process the insurance claim.

**Non-Medicare Patients**

In consideration of services to be rendered, I hereby assign and transfer to Activator Health Center any benefits payable to or for my benefit under hospitalization, sickness or accident insurance, and any other insurance coverage, to include major medical or P.I.P., Medpay for the payment of such services rendered. I agree to cooperate, aid and assist Activator Health Center in procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance companies may require for payment.

I further assign and transfer to Activator Health Center an interest in any cause of action I may have arising out of injuries directly or indirectly resulting in this period of treatment. This assignment includes insurance benefits occurring to me under uninsured motorist coverage.

**I ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES. I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND IT.**

**Patient Signature:**

\_\_\_\_\_  
(If patient is a minor, a parent or guardian signature is required)

\_\_\_\_\_  
(Responsible party)

Witness \_\_\_\_\_

Date \_\_\_\_\_

# HIPAA Notice of Privacy Practices

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**Activator Health Center**  
**2950 N 7<sup>th</sup> St. Ste 100**  
**Phoenix, AZ 85014**  
**602-445-7575**

**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 protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

## **1. Uses and Disclosures of Protected Health Information**

### **Uses and Disclosures of Protected Health Information**

Your protected health information 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.

**Treatment:** We will use and disclose your protected health information 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 protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information 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 relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order 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 protected health information 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 protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration 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 or determine our compliance with the requirements of Section 164.500.

**Appointment reminder:** We may contact you via the telephone or leave a voicemail to remind you of a scheduled appointment. In addition we may contact you to re-schedule an appointment if necessary.

**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.

### **Your Rights**

Following is a statement of your rights with respect to your protected health information.

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

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

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

**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.

**You may have the right to have your physician amend your protected health information.** 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 with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

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

### **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 October 1, 2008.**

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 protected health information. 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 Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

# Informed Consent

Health care is associated with some degree of risk for potential side-effects or unanticipated problems. We perform chiropractic adjustments with the Activator Instrument only, a low-force adjusting tool.

Chiropractic adjustments involve the moving of bones to improve alignment and range of motion. The most serious problem associated with chiropractic adjustments is a stroke following adjusting of the neck in what is called the “extension-rotation-thrust” adjustment. We do not perform this adjustment!

Other possible complications include the following:

Soft tissue injuries, fracture of bones and injury to the intervertebral disc may occur with forceful adjustments. We do not perform these adjustments.

It is possible that you may develop very small areas of superficial bruising at the point of contact of the adjusting instrument on the skin, but this is minimal and goes away in a day or two. This is rare, but can happen in patients with fragile skin or those who are taking blood thinners.

Post-treatment soreness: There may be “soreness” following an adjustment. This is due to the muscles beginning to contract correctly again and the joints being re-aligned. It is similar to the soreness and stiffness one gets when they start exercising after a long period of no exercise. We have found that the patients who do develop soreness following the first treatment are the patients who usually heal the fastest.

We do not “twist, crack, or pop” your spine. The Activator Methods Technique of adjusting is a low-force and safe form of chiropractic adjusting.

By signing this form you acknowledge that you are aware of these possible complications and agree to allow the doctor to adjust you with the Activator.

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Date

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Patient’s Signature

We know there can be various reasons for your office visit today, and more than one of the following questions might apply. However, please pick only the ONE that most relates to you currently.

1. Are you here today because, although you feel healthy, you want to have an even greater level of health?
2. Are you here today because, although you feel healthy, you want to help prevent an illness or possible injury?
3. Are you here today because, although you feel healthy, you have a tendency to be at risk for injuring yourself and want to prevent that from happening?
4. Are you here today because you are injured or ill and seeking care, without having to do any home therapies or modify activities outside of this office?
5. Are you here today because you are injured or ill and seeking care, and want to have home therapies and activities that you can do to help yourself outside this office?