KLECKNER CHIROPRACTIC CLINIC

PERSONAL INFORMATION

Today's Date: ____/____/_____

First Name: _____ **M.I.**____ **Last Name:**_____ **Preferred Name:**_____

Address: _____ **City:**_____ **State:**_____ **Zip:**_____

Birthdate: ___/___/_____ **Age:** _____ **Gender:** ☐ Male ☐ Female ☐ Unspecified **SS Number:** (*last four only*) _____

Primary Phone: (____) _____-_____ **Cell Phone:** (____) _____-_____ **Work Phone:** (____) _____-_____

Preferred Email Address: _____
By providing my email address, I authorize my doctor to contact me via the email address provided.

Contact Method: (*check one*) ☐ Primary Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Occupation: _____ **Employer:** _____

Status: (*check one*) ☐ Single ☐ Married ☐ Other **Spouse's Name:** (*if applicable*) _____

Race: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
☐ Native American ☐ Other:_____ ☐ I choose not to specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I choose not to specify

Preferred Language: ☐ English ☐ Spanish ☐ Other_____ ☐ I choose not to specify

Referred By: _____ **Height:**_____ **Weight:**_____

Emergency Contact Information: Name:_____ Phone Numer: (____) ____-_____
Relationship: ☐ Child ☐ Parent ☐ Spouse ☐ Other:_____

REASON FOR VISIT

Reason for your complaint today:_____

Cause of this complaint(s): _____

Date this complaint began: ___/___/_____

Describe the feeling of your complaint(s): (*Circle all that apply*) Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing
Stabbing / Shooting / Burning / Cramping / Tingling / Numbness

Describe what aggravates your complaint(s): (*Circle all that apply*) Sitting / Standing / Walking / Getting up from seated
Inactivity / Sleeping / Physical Activity / Twisting / Reaching
Sneezing / Coughing / Everything / Other: _____

Describe what relieves your complaint(s): (*Circle all that apply*) Sitting / Standing / Walking / Resting / Exercise / Ice / Medicine
Chiropractic / Laying down / Heat / Nothing / Other: _____

Is your complaint interfering with your daily activities? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Extremely

KLECKNER
CHIROPRACTIC CLINIC

PAIN SCALE

Place an "X" on the drawing below on the areas causing you pain and a letter describing it.

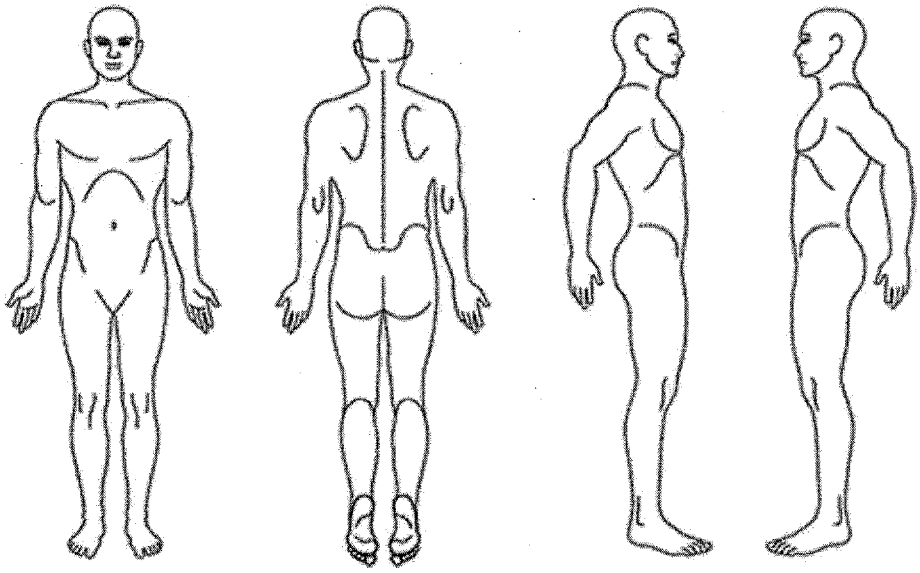
A= Ache

B= Burning

S= Stabbing

N= Numbness

P= Pins and Needles



Please circle the number that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

MEDICATION AND ALLERGIES

Current medications, including frequency and dosage if known.

If there are no current medications, check here: ☐

1)_____ 5)_____

2)_____ 6)_____

3)_____ 7)_____

4)_____ 8)_____

List any known allergies you have had to any medications.

If no allergies are known, check here: ☐

1)_____ 3)_____

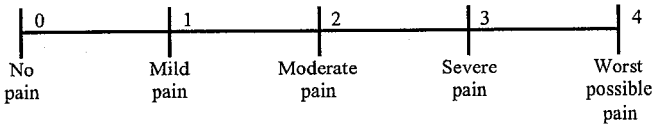
2)_____ 4)_____

Functional Rating Index

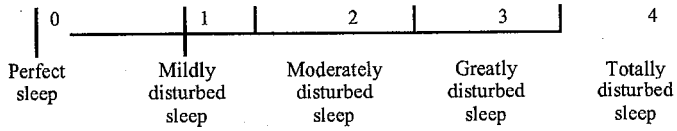
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

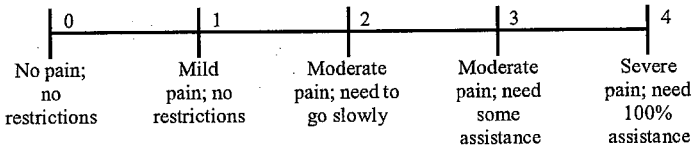
1. Pain Intensity



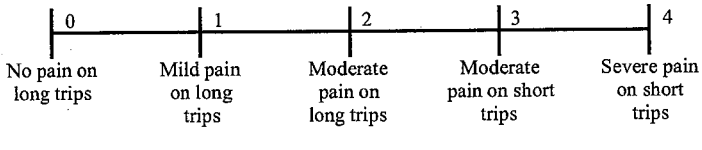
2. Sleeping



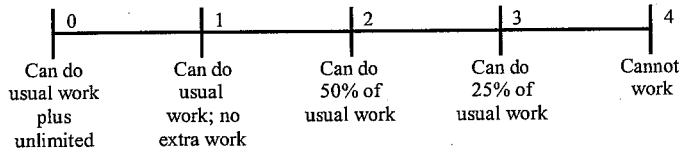
3. Personal Care (washing, dressing, etc.)



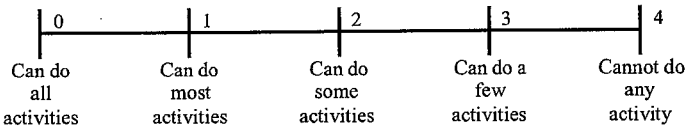
4. Travelling (driving, etc.)



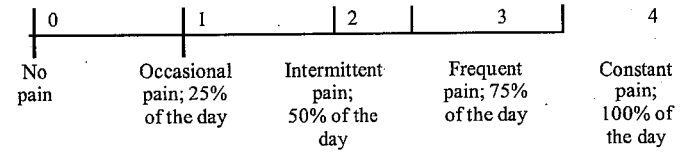
5. Work



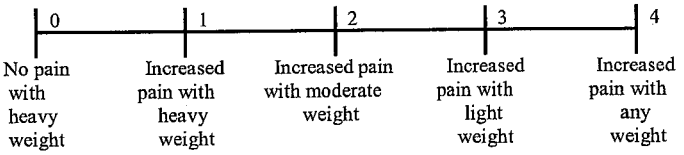
6. Recreation



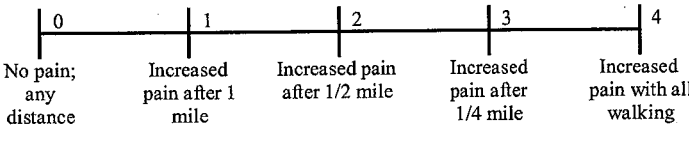
7. Frequency of Pain



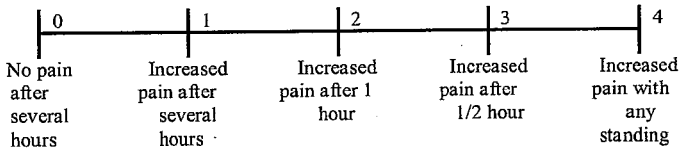
8. Lifting



9. Walking



10. Standing



Patient's Signature _____ **Date** _____

For Office Use Only:

Practitioner ID#: _____

Total Score _____ **/ 40**

Clinical Diagnosis Codes:

Patient ID#: _____

NOTICE OF PRIVACY PRACTICES

Kleckner Chiropractic Clinic

250 West 1st Street, Grimes IA 50111 (515) 986-2233

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This Notice of Privacy 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. "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 condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Treatment: We may use and disclose your personal information to provide you with treatment or services. For example, we may use your health information to prescribe a course of treatment or make a referral. We will record your current healthcare information in a record so, in the future, we can see your medical history to help in diagnosing and treatment, or to determine how well you are responding to treatment. We may provide your health information to other health providers, such as referring or specialist physicians, to assist in your treatment. Should you ever be hospitalized, we may provide the hospital or its staff with the health information it requires to provide you with effective treatment.

Payment: We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.

Health Care Operations: We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.

Other Permitted and Required Uses and Disclosure will be made **only** with your consent, authorization or opportunity to object unless required by law. You may revoke the 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 HEALTH INFORMATION RIGHTS

The following are statements of your rights with respect to your protected health information.

Right to Obtain a Paper Copy of This Notice: You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. You have a right to information that is stored electronically that is not in EHR software, including information stored in MS Word, Excel, PDF, plain text and other electronic formats. To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your **medical information, we may** charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record. You have a right to have this information with-in 30 days of receipt of your request.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we retain the information. To request an amendment, your request must be made in writing and submitted to our privacy officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for [name of provider];

- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If we deny your request for amendment, you may submit a statement of disagreement. We may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures of your health information made by us. In your accounting, we are not required to list certain disclosures, including:

- disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations, however, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years;
- disclosures made pursuant to your authorization;
- disclosures made to create a limited data set;
- disclosures made directly to you.

To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper or electronically by email). The first accounting of disclosures you request within any 12 month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by federal and state law, we may temporarily deny your request for an accounting of disclosures.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care. You have a right to restrict certain disclosures of Protected Health Information to a health plan where you have paid out of pocket in full for the healthcare item or service. As noted above, we are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure, or both and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e-mail. To request confidential communications, you must make your request in writing to our privacy officer. We will accommodate all reasonable requests.

Right to Receive Notice of a Breach: We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. **We will not retaliate against you for filing a complaint.** To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.

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 protect health information. We are also to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

By signing this Agreement, you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Signature:_____ Date_____

Print Name:_____

Effective Date: September 9, 2016

KLECKNER
CHIROPRACTIC CLINIC

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment. The primary treatment used by a Doctor of Chiropractic is spinal and extremity manipulative therapy. The Doctor will use that procedure to treat you. The Doctor may use his hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," and you may feel a sense of movement. As part of the analysis, examination, and treatment, you are consenting to spinal and extremity manipulative therapy, palpation, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis, and physiotherapy procedures.

The material risks inherent in chiropractic adjustment. As with any healthcare procedure, there are certain complication which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures (generally resulting from some underlying weakness of the bone), disc injuries, dislocations, muscle strain, stroke, cervical myelopathy, rib strains and separations. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

The availability and nature of other treatment options. Other treatment options for your condition may include: Self-administered over-the-counter analgesics and rest; Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and pain-killers; Physical Therapy; Hospitalization; Surgery. If you chose to use any of these other treatment options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated. Potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. This may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

Consent to treat minor. As of this date, I have the legal right to select and authorize health care services for the minor to be treated and hereby request and authorize Dr. Ethan J. Kleckner to render him/her chiropractic evaluation and treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Ethan J. Kleckner and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Date: _____ Date: _____

Patient Name: _____ Doctor name: Ethan J. Kleckner, DC

Patient Signature: _____ Doctor Signature: _____

Signature Parent/Guardian (if minor): _____