Louisville
HEALTHSOLUTIONS
CHIROPRACTIC – REHAB – WELLNESS

Dr. James Drew Anderson, D.C.

How did you hear about our office? ☐ Phone Book ☐ Sign ☐ Provider Manual ☐ Patient ☐ Dr. Referral ☐ Internet ☐ Other

If referred by a patient or another provider, who may we thank for their kind referral? ____

Patient Name:_________________________________

Prefers to be called:____________________________

Date of Birth:___/___/_________ Gender: M / F

Address:_______________________________________

____

Employer:___________________________________

Occupation:_________________________________

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Home Phone:___________________________________

Cell Phone:_____________________________________

Work Phone:____________________________________

Best Number to Reach You: Home / Cell / Work

Email Address:__________________________________

*May we send you text reminders regarding scheduled appointments? YES / NO

Emergency Contact Name:_________________________

Relationship:___________________________________

Telephone:_____________________________________

Insurance Information

Primary Insurance _______________________

Subscriber/Policy ID:____________________________

Subscriber Name:___________________

Group #:_______________

Relationship to you: Self / Spouse / Child

Subscriber Date of Birth:___________________

Secondary Insurance____________________

Policy #/ID________________________________

PATIENT MESSAGING CONSENT

By supplying my home phone number, mobile number, email address, and any other personal contact information, I authorize my healthcare provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment (s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balance due, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events.

ACCOUNT INFORMATION

I hereby give my authorization/consent to treat me or my minor child as named herein on this form. Our office policy requires payment in full for all services and goods rendered at the time of your visit to the office, unless other arrangements have been made with the Office Manager. I clearly understand and agree that all services and goods rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I authorize payment of any and all benefits, medical or otherwise, to the physician for benefits due me for the services and/or goods rendered. I further authorize the physician and/or supplier to release my information as required to process any and all insurance claims. I understand the above information in this entirety and hereby guarantee that this form was completed accurately to the best of my knowledge. I also understand that it is my responsibility to inform this office, in a timely manner, of any and all changes to this information.

____ ________________________________

Patient Signature (Parent or Guardian Signature if Patient is a Minor) **Date Signed**

Name:____

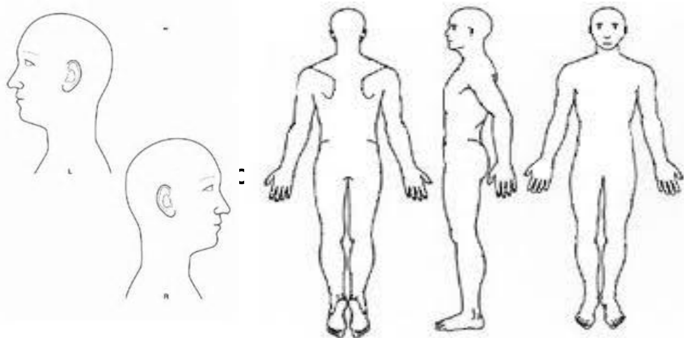
PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. What Do you hope to achieve from treatment in this office? (Check all that apply)
   ____ Pain Reduction _____ Correction of the Problem _____ To keep my body as healthy as possible
2. Have you ever been to a chiropractor before? _____ No _____ Yes If "Yes", when? ________________________
3. Have you ever seen another Doctor for this problem? _____ No _____ Yes If "Yes", when? ________________________
4. Were you ever injured in an automobile accident _____ No _____ Yes If "Yes", when? ________________________
5. either as a passenger or the driver?
6. Were you ever injured at work or as the result of _____ No _____ Yes If "Yes", when? ________________________
7. employment?

CHECK ANY OF THE FOLLOWING THAT PERTAIN TO YOUR MEDICAL HISTORY AND CURRENT SYMPTOMS:

- ☐ Allergies
- ☐ Anemia
- ☐ Arm / Shoulder Pain
- ☐ Arthritis
- ☐ Asthma / Difficulty Breathing
- ☐ Bladder Infection
- ☐ Blurred Vision
- ☐ Buzzing or Ringing in the Ears
- ☐ Cancer
- ☐ Chest Pain / Heart Disease
- ☐ Cold, Tingling Extremities (Arms or Legs)
- ☐ Concentration Loss
- ☐ Constipation / Diarrhea / Colon Disease
- ☐ Convulsions / Epilepsy
- ☐ Cold Sweats
- ☐ Depression
- ☐ Diabetes
- ☐ Disc Problems
- ☐ Dizziness
- ☐ Ear Infections
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Gallbladder Symptoms
- ☐ Head seems too "heavy"
- ☐ Headaches / Migraines
- ☐ Hepatitis / Liver Symptoms
- ☐ Hip Pain
- ☐ Indigestion / Stomach Problems
- ☐ Insomnia / Sleep Difficulty
- ☐ Joint Problems
- ☐ Kidney Problems
- ☐ Loss of Energy
- ☐ Loss of Memory
- ☐ Loss of Smell / Taste
- ☐ Low Back Pain
- ☐ Menstrual Pain / P.M.S.
- ☐ Mid-back Pain
- ☐ Neck Pain
- ☐ Nervousness
- ☐ Numbness
- ☐ Pain down legs
- ☐ Pinched Nerves
- ☐ Poor Circulation
- ☐ Poor Posture
- ☐ Scoliosis
- ☐ Sensitivity to light
- ☐ Sinus Problems
- ☐ Stress / Tension
- ☐ Tight Muscles
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Weight Loss
- ☐ Other ________________________

PLEASE OUTLINE, ON THE DIAGRAM(S) BELOW, THE AREA(S) OF YOUR DISCOMFORT:



OUT OF ANY AND ALL OF YOUR CONCERNS, WHICH IS **THE MOST TROUBLESOME** TO YOU? ________________________

Use the following symbols, as applicable, to diagram areas of discomfort:

A = Aching	N = Numbness
B = Burning	R = Throbbing
C = Cold	S = Stabbing
H = Hypersensitivity	T = Tingling

PAIN SCALE:

HOW WOULD YOU RATE YOUR PAIN ON A SCALE OF 1-10?

(1=No Pain / 10= Unbearable Pain)

____

HOW HAS THIS AFFECTED YOUR LIFE:

- Have you missed work? Y / N
- Has the quality of your work been affected? Y / N
- Are you able to do household chores? Y / N
- Has this problem interfered with your social life? Y/N
- Has it interfered with spending time with family and friends? Y / N
- Has it interfered with your recreational activities (exercise, golf, tennis, fishing, etc.)? Y / N
- Has it affected your life in any other way? ____

- **OCCUPATIONAL INFORMATION:**

Job involves:
- Sitting
- Standing
- Lifting
- Desk
- Counter
- Bending
- Stooping
- Twisting
- Turning

Do any of your work activities aggravate your present main complaint? Describe:

____

____

____

Types of shoes:
- High heels
- Boots
- Arch Supports

Physical activity at work:
- Sedentary
- Light Manual Labor
- Moderate / Heavy Manual Labor

Informed Consent for Chiropractic Adjustments & Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic. I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interest. I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

HIPAA Notice of Privacy Practices

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

If you have any questions about the above notice, please contact our Privacy Officer, Nicole Anderson at (502) 423-0500

Our Obligations: We are required by law to: Maintain the privacy of protected health information, give you the notice of your legal duties and privacy practices regarding health information about you, and follow the terms of our notice that is currently in effect **How We May Use and Disclose Health Information:** Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's privacy officer. **Treatment.** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care. **Payment.** We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment. **Health Care Operations.** We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the chiropractic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities. **Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services.** We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you. **Individuals Involved in Your Care or Payment for Your Care.** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort. **Research.** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes. **As required by law.** We will disclose Health Information when required to do so by international, federal, state, or local law. **To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment. Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract. **Organ and Tissue Donation.** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation. **Military and Veterans.** If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military. **Workers Compensation.** We may release Health Information for workers compensation or similar programs. These programs provide benefits for work-related injuries or illness. **Public Health Risks.** We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law. **Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. **Lawsuits and Disputes.** If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. **Law Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the persons agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime. **Coroners, Medical Examiners, Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties. **National Security and Intelligence Activities.** We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations. **Protective Services and Intelligence Activities.** We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations. **Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution. **Your Rights:** You have the following rights regarding Health Information we have about you: **Right to Inspect and Copy.** You have the right to inspect and copy Health Information that we may use to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer. **Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer. **Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. **Right to Request Confidential Communication.** You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests. **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner. **Complaints:** If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.** By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

____ ________________________

Patient Signature **Date**