

GAVAZZI FAMILY CHIROPRACTIC, PROFESSIONAL LLC**NEW PATIENT INFORMATION**

Today's Date:

Last Name:

First Name:

Middle Initial:

Date of Birth:

Address:

City/State/Zip:

Phone:

Alternate Phone:

Email Address:

Marital Status: (Please Circle One)

Married

Widowed

Divorced

Single

Spouse's Name:

Children's Names & Ages:

Other doctors you've seen recently:

Medicines you take:

Vitamins/Supplements you take:

Ever diagnosed with cancer?

What kind?

Surgeries you've had and date of occurrence:

Who is financially responsible for this bill?

Emergency Contact:

Phone:

GAVAZZI FAMILY CHIROPRACTIC, PROFESSIONAL LLC

PATIENT HISTORY

Please Fill in the Appropriate Spaces Below: (All information you give is confidential)

Patient Name: _____

Date of Birth: _____

Major Complaint: _____

How long have you had this condition? _____

When did this condition begin? _____

What other doctors have you seen for this condition: _____

Have you lost workdays? ☐ Yes ☐ No If yes, how many days? _____

Have you had this same condition before? ☐ Yes ☐ No If yes, when? _____

Was the injury the result of an accident? ☐ Auto accident ☐ Work accident ☐ No If yes, when? _____

Previous Chiropractic Care? ☐ Yes ☐ No If yes, what was your previous chiropractor's name? _____

What was the reason for your initial visit? _____

Please Mark If You Have Had Any Of These Complaints In The Last 12 Months:

- | | | |
|--|--|--|
| <input type="checkbox"/> Fractured bones
<input type="checkbox"/> Auto accidents
___ 0-1 years ago
___ 2-5 years ago
___ 6 years or more
<input type="checkbox"/> Other accidents or falls
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Convulsions, epilepsy
<input type="checkbox"/> Skin problems
<input type="checkbox"/> Cancer
<input type="checkbox"/> Frequent colds or flu
<input type="checkbox"/> Depression
<input type="checkbox"/> Irritability
<input type="checkbox"/> Anemia
<input type="checkbox"/> Allergy or sinus issues
<input type="checkbox"/> Under stress
<input type="checkbox"/> Eating disorders
<input type="checkbox"/> Trouble sleeping
<input type="checkbox"/> Trouble concentrating
<input type="checkbox"/> Learning disability
<input type="checkbox"/> Mood changes | <input type="checkbox"/> Neck pain or stiffness
R L
<input type="checkbox"/> Numbness, tingling, or pain in
arms, hands, or fingers
R L
<input type="checkbox"/> Jaw pain or click (TMJ)
R L
<input type="checkbox"/> Difficulty in excessive standing,
sitting, riding, bending, lifting,
or twisting
<input type="checkbox"/> Shoulder pain
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Ringing in ears R L
<input type="checkbox"/> Hearing loss R L
<input type="checkbox"/> Blurred or double vision
<input type="checkbox"/> Upper back pain or stiffness
<input type="checkbox"/> Mid back pain or stiffness
<input type="checkbox"/> Lower back pain or stiffness
<input type="checkbox"/> Pain with cough or sneeze
<input type="checkbox"/> Hip pain R L
<input type="checkbox"/> Headaches
<input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Numbness, tingling, or pain in
buttocks, legs, feet, or toes
R L
<input type="checkbox"/> Foot trouble R L
<input type="checkbox"/> Heart problems
<input type="checkbox"/> Stroke
<input type="checkbox"/> High/low blood pressure
<input type="checkbox"/> Chest pain or asthma
<input type="checkbox"/> Liver trouble
<input type="checkbox"/> Gall bladder problems
<input type="checkbox"/> Digestive problems
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Impotence
<input type="checkbox"/> Kidney problems
<input type="checkbox"/> Menstrual problems, PMS
<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Ear infections
<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> AIDS or HIV |
|--|--|--|

Any other conditions or complaints not listed above? _____

Gavazzi Family Chiropractic, Professional LLC

TERMS OF ACCEPTANCE

CHIROPRACTIC INFORMED CONSENT

When a patient seeks chiropractic healthcare and we agree to provide this care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method with which it will be obtained. This prevents any confusion and/or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of Vertebral Subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses. This misalignment results in a lessening of the body's God-given, innate ability to express its maximum health potential.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other than Vertebral Subluxation; however, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will inform you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by other healthcare professionals. Our **ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's God-given, innate wisdom. Our only method is specific adjusting to correct Vertebral Subluxation.

Patient Name: _____ Date of Birth: _____

My signature below acknowledges that I have read and fully understand the above statements and gives my consent to the doctor and staff of Gavazzi Family Chiropractic, Professional LLC to perform any examinations, treatments, and further assessments that are deemed necessary for my care.

Signature of Patient or Personal Representative

Date

Print Name

Personal Representative's Title (e.g., Parent, Guardian, Executor of Estate, Health Care Power of Attorney)

GAVAZZI FAMILY CHIROPRACTIC, PROFESSIONAL LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

I have been given a copy of Gavazzi Family Chiropractic Professional LLC's Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Gavazzi Family Chiropractic, Professional LLC has the right to change this Notice at any time. I may obtain a current copy by contacting Gavazzi Family Chiropractic, Professional LLC, or by visiting the Gavazzi Family Chiropractic, Professional LLC web site at <http://www.middlefieldchiropractic.com/>

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

Signature of Patient or Personal Representative Date

Print Name

Personal Representative's Title (e.g., Parent, Guardian, Executor of Estate, Health Care Power of Attorney)

For Office Use Only

Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:

2. Describe the steps taken to obtain the patient's or personal representative's signature on the Acknowledgement:

Completed by:

Signature of Office Representative Date

Print Name

Gavazzi Family Chiropractic, Professional LLC

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 IT CAREFULLY.**

Gavazzi Family Chiropractic, Professional LLC is committed to maintaining the privacy of your **PROTECTED HEALTH INFORMATION ("PHI")**. PHI includes information about your health condition and the care and treatment you receive from us. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. We are required by law to maintain the privacy of PHI, provide our patients with notice of our legal duties and privacy practices with respect to PHI, and follow the terms of our notice that is currently in effect.

PERMITTED DISCLOSURES

The following describes the ways we may use and disclose health information that identifies you. Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to Gavazzi Family Chiropractic, Professional LLC.

Treatment – We may use and disclose PHI 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 PHI so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

Health Care Operations – We may use and disclose PHI for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office.

Appointment Reminders, Greeting Cards, Treatment Alternatives and Health Related Benefits and Services - We may use and disclose PHI to contact you to remind you that you have an appointment with us or to send you a greeting card. We also may use and disclose PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Directory/Sign-In Log – We maintain a directory of and sign-in log for individuals seeking care and treatment in the office. The directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within our office. This information may be seen by, and is accessible to, others who are seeking care or services in our offices.

Individuals Involved in Your Care or Payment for Your Care – When appropriate, we may share PHI 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 PHI for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose PHI 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 long as they do not remove or take a copy of any PHI.

SPECIAL SITUATIONS

As Required by Law. We will disclose PHI when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety - We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates - We may disclose PHI to our business associates that perform functions on our behalf or 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 as specified in our contract.

Organ and Tissue Donation - If you are an organ donor, we may use or release PHI 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 armed forces, we may release PHI as required by military command authorities. We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation - We may release PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks - We may disclose PHI for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities - We may disclose PHI 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.

Data Breach Notification Purposes - We may use or disclose your Protected PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Lawsuits and Disputes - If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI 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 PHI 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 a crime even if, under certain very limited circumstances, we are unable to obtain the person's 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 to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors - We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security and Intelligence Activities - We may release PHI to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others - We may disclose PHI 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 under the custody of a law enforcement official, we may release PHI to the correctional institution or law enforcement official. This release would be 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) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief - We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your PHI will be made only with your written authorization:

1. Uses and disclosures of PHI for marketing purposes; and
2. Disclosures that constitute a sale of your PHI

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer, and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS

You have the following rights regarding PHI we have about you:

Right to Inspect and Copy - You have a right to inspect and copy PHI that may be used 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 Health Information, you must make your request, in writing, to Gavazzi Family Chiropractic, Professional LLC. We have up to 30 days to make your PHI available to you, and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records - If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach - You have the right to be notified upon a breach of any of your unsecured PHI.

Right to Amend - If you feel that PHI 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 Gavazzi Family Chiropractic, Professional LLC.

Right to an Accounting of Disclosures - You have the right to request a list of certain disclosures we made of PHI 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 Gavazzi Family Chiropractic, Professional LLC.

Right to Request Restrictions - You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Gavazzi Family Chiropractic, Professional LLC. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments - If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

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 by mail or at work. To request confidential communications, you must make your request, in writing, to Gavazzi Family Chiropractic, Professional LLC. 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 may 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 at our web site, <http://www.middlefieldchiropractic.com/>

This notice is effective as of January 1, 2015. Gavazzi Family Chiropractic, Professional LLC reserves the right to change the terms of this Privacy Notice and to make the new terms applicable to your PHI so long as we have provided you with advance notice of our revised Privacy Notice and have obtained your signature accepting its terms.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. We will post a copy of our current 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 rights have 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 Dr. Robert Gavazzi. All complaints must be made in writing. You will not be penalized for filing a complaint.

You may contact our office at:

Gavazzi Family Chiropractic, Professional LLC
15914 W. High Street Middlefield, OH 44062
(440) 632-9504