CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need assistance, please ask our receptionist, and we will be happy to have our Patient Services Representative help you.

Your Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Pager: _____ Cell Ph: _____

Age: _____ Date of Birth: _____ E-mail: _____

Marital Status: ☐M ☐S ☐D ☐W Drivers License # _____

Your Occupation: _____ Employed by: _____

Phone #: _____ Address: _____

Is your visit due to an accident? ☐ Yes / ☐ No

Are you are Medicare Patient? ☐ Yes / ☐ No Medicare #: _____

Your Spouse's Name: _____

Spouse's Employer: _____ Spouse's work phone #: _____

Name of person to contact in case of emergency: _____

Their home and work phone number: _____

Name of nearest relative not living with you: _____

Their phone number: _____

Who referred you to this office so we may thank them? _____

Referring Physician: _____

In order to determine if care can be of benefit to you, this office will extend the courtesy of an initial consultation without charge. If the doctor might be able to help you with your condition, are you interested in seeking care? ☐ Yes ☐ Unsure

THERE WILL BE NO CHARGED SERVICES WITHOUT YOUR INFORMED CONSENT.

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

Patient's Signature: _____ Date _____

Parent or Guardian: _____

Signature: _____ Date _____

Please complete the information on the opposite side. Thank you!

Present Complaints (please circle the appropriate ones) Page 3

Headache
Mental dullness
Loss of memory
Dizzy
Neck Pain
Fainting
Upper back pain
Lower back pain
Neck restriction
Nervousness
Feet/hands cold
Depression
Pins and needles in arms
Rib pain
Neck stiffness
Shortness of breath
Upper back stiffness
Lower back stiffness
Eye strain / pain
Fear
Head seems heavy
Confusion
Constipation
Unbalanced
Chest pain
Ears ringing/buzzing
Midback pain
Blurred vision
Loss of taste
Irritability
Pins and needles in arms Right / Left
Pins and needles in hands Right / Left
Pins and needles in legs Right / Left
Midback stiffness
Double vision
Loss of smell
Tension

Difficulty in: ☐ Standing, ☐ Sitting, ☐ Bending, ☐ Walking

Pain radiation to the: ☐ Right arm, ☐ Left arm, ☐ Right leg, ☐ Left leg

Cannot lift: ☐ Light, ☐ Moderate, ☐Heavy, ☐ Repetitive

Pain radiating to: ☐Neck, ☐ Base of skull, ☐ Ribs, ☐ Shoulders, ☐ Arms

Pain in the: ☐ Foot, ☐ Ankle, ☐ Knee, ☐ Hip, ☐ Heel spurs

OTHER: _____

Since the time this (these) complaint(s) began, what, if anything, have you tried that **did not** work? _____

Has the problem interrupted your sleep? Yes / No How: _____

Does anyone in your family have the same or similar condition: Yes / No

Who: _____

List any doctors or therapists that you have seen for this complaint:

1. _____ Specialty _____
2. _____ Specialty _____
3. _____ Specialty _____

Relevant medical history: (Please circle the conditions you have or had previously)

Arthritis	Epilepsy	Muscular Dystrophy
Asthma	Fibromyalgia	Neck pain or spasms
Anemia	Hand or wrist pain	Neuritis
Back pain or spasm	Headaches	Numbness
Cancer	Heart problems	Polio
Concussion	Hepatitis	Rheumatic Fever
Convulsion	High blood pressure	Sinus trouble
Diabetes	HIV	Sciatica
Digestion problems	Measles	TB
Dizziness	Multiple sclerosis	Venereal disease

Please complete the information on the opposite side. Thank you!

Patient Name: _____ **Date:** _____

Present Complaints

List any operations that you've had and approximate dates:

1. _____ Date: _____ Dr: _____
2. _____ Date: _____ Dr: _____
3. _____ Date: _____ Dr: _____
4. _____ Date: _____ Dr: _____

Are you allergic to any medication? Please list: _____

_____

Are you taking any medications? Please list: _____

_____

Do you wear Orthotics (shoe inserts)? ☐ Yes / ☐ No

If yes, what type? _____

Are you pregnant? ☐ Yes / ☐ No Due date: _____

Do you: Smoke: ☐ Yes / ☐ No Amount per day: _____

Drink: ☐ Yes / ☐ No ☐ Light ☐ Medium ☐ Heavy

Exercise: ☐ Never ☐ Sometimes ☐ Frequently ☐ Regularly

Does anyone in your family have a similar health related problem? ☐ Yes / ☐ No

Who:_____ What condition: _____

Care they are receiving: _____

Is it helping? ☐ Yes / ☐ No

May we contact them regarding their condition? ☐ Yes / ☐ No

Patient Name: _____ **Date:** _____

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 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.

I. 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, marketing and fundraising activities, 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.

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 Healtheare 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 April 14, 2003.

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_____

Hochman Family Chiropractic
"Where our family heals your family"
Miramar Town Center
11613 Red Road
Miramar, Florida 33025

Dr. Ian Hochman
Chiropractic Physician

Tel: 954-392-BACK (2225)
Fax: 954-432-6305
ihochmandc@aol.com

Informed Consent for Examination and Treatment

I hereby consent to the performance of examination and treatment on me, _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.
Date of last menstrual period _____.

_____ _____
Patient's Name (Print) Patient's Signature

_____
Date

_____
Witness