4004 Genesee Place Suite 213 • Woodbridge, VA 22192 • p: 703-680-4344 • f: 703-680-0440

PATIENT INFORMATION *(Please print)*

Name ____ Date ______________SSN ________________________

Address ____ City ___________________ State _____ Zip _________

Birth Date _______________________Age ________

Home Phone__________________________________

Work Phone _________________________________

Cell Phone __________________________________

(*Circle one*) Male Female Minor Married Divorced Widowed Single Separated

Employer _____________________________________ Occupation _____________________________________

Business Address_________________________________ City ___________________ State _____ Zip _________

Spouse's or Parent's Name _________________________

Emergency Contact____ Phone ___________________________

SYMPTOMS

Reason for visit ________________________________ When did they symptoms start? ________________________

How did the symptoms start? ____

Where specifically are the symptoms located? ____

Is the pain getting worse with time? **Yes** **No** What makes the symptoms better? ________________________

What makes the condition worse? ____

Circle all the appropriate descriptions of your symptoms:

1. Constant Comes and Goes Infrequent
2. Sharp Dull Aching Numbness Shooting
3. Tingling Cramps Stiffness Swelling
4. Worse: in the AM, while sleeping, with activity
5. Relieved: with activity, with rest, with medication ____
6. The pain radiates (travels) to:____

Which activities are difficult to perform? Sitting Standing Walking Bending Lying down

Rate the severity of your pain (1 is mild, 10 is excruciating pain) 1 2 3 4 5 6 7 8 9 10

What treatment have you already tried? Medication____

Physical therapy ________________________ Surgery _______________________Other______________________

What other doctors have you seen for this condition?

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HEALTH HISTORY (Circle only those that apply)

AIDS/HIV	Anemia	Abdominal surgery	Arthritis	Bleeding Disorder
Cancer	Depression	Diabetes	Epilepsy	Fibromyalgia
Irregular Heart Beat	Hepatitis	Osteoporosis	Pacemaker	
Prostrate Problems	Prosthesis	Stroke	Thyroid Problems	

Other ____

(Women only) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

List all medications you are taking: ______________________________

Do you smoke? Yes No ________ packs per day. How much alcohol do you drink per week? __________

How many caffeinated beverages do you drink per day? ________________________

How often do you exercise? ____________________ What type of exercise? ____________________

What is your stress level? ____________________________________

List any significant injuries or traumas you have had in the past: ________________________

____

ASSIGNMENT AND RELEASE

I certify that I have read and understand the above information. The above questions have been accurately answered. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Kline Chiropractic & Wellness, PLLC any insurance benefits otherwise payable to me. I understand that I am responsible for all charges. If the doctor is a participating provider for my insurance, I understand that I am responsible for any co payments, deductibles, or other charges in accordance with my plan. I authorize the use of this signature on all insurance submissions. Patient accounts with balances over 30 days old are charged and annual interest rate of 12% (1% monthly).

Signature of patient (or parent) ______________________________ **Date** ____________________

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

In the course of your care as a patient at Kline Chiropractic & Wellness, PLLC, we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or maybe responsible for the payment of services provided to you.
- Your name, address, phone number, e-mail address, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have the right to request restrictions on our use of your protected health information for treatment, payment, and operations purposes. Such requests are not automatic and require the agreement of this office.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communi-cations and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care
- If we are ordered by the courts or another appropriate agency

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information, you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form, please advise us in writing as to your preferences

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities or you would like further information on our privacy policies and practices, please contact: Dr. Erin W. Kline.

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary, your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

Name (please print)

____

Signature

____

Date ________________________

IF A MINOR:

Personal Representative
(printed)__________________________________

Personal Representative
(signature)________________________________

Date ________________________

Description of the authority to act on behalf of the patient

____