TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

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

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

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

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures and to correct joint dysfunctions associated with extremities.

NOTE: It is understood and agreed the amount paid to *Shimer Chiropractic, PC* for x-rays are for examination of spinal alignment only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office. Also patient understands that *Shimer Chiropractic, PC* **does not** have on-site x-rays and provide invasive testing/treatment. In the doctor's professional opinion, should any of our patients need x-rays, additional diagnostic testing, or other forms of health care services, they will be referred to an appropriate provider or facility, when indicated.

INFORMED CONSENT TO EXAMINATION AND TREATMENT

I do hereby authorize the doctor(s) of *Shimer Chiropractic, PC* and any therapist(s) and chiropractic technician(s) working at the clinic to administer such care that is necessary for my particular case (or my child/dependent/ward's particular case). This care may include consultation, examination, spinal adjustments, extremity adjustments and other chiropractic procedures, including various modes of physical therapy, spinal flexion/distraction, and spinal alignment assessment on x-rays or any other procedure that is advisable, and necessary for my health care. I intend this consent form to cover the entire course of treatment for my present condition(s) and any future condition for which I seek treatment.

I understand and have been informed that during the process of a thorough examination that my current symptoms/condition may be exacerbated due to the nature of the examination. 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 clinical judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic. There are no guaranties or assurances concerning the intended results of the treatments.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments/manipulation and other procedures related to my health care (or my child's/dependent's/Ward's health care). I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and have been 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, disk injuries, dislocations, sprains, paralysis, increased symptoms and pain, or no improvement of symptoms and pain. A rare but serious risk associated with neck manipulation is stroke. 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 clinical judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal and/or extremity structural and or biomechanical conditions treated at this clinic. There are no guaranties or assurances concerning the intended results of the treatments.

I also clearly understand that if I do not follow the Doctor's specific recommendations at this clinic, I will not receive the full benefit from the programs offered, and if I terminate my care prematurely, all fees incurred will be due and payable at that time. I understand that *Shimer Chiropractic, PC* **does not** accept or bill insurance, Medicare, and/or any third party carrier for payment and I shall be personally liable for any and all of the services used by the doctor.

I, ____, have read or have had read to me, the above consent to care. I have also had the opportunity to
(PRINT patient name or Parent/Guardian)
ask questions about the care, and my questions have been fully answered. By signing below, I consent to this treatment. I intend this consent form to cover the entire course of treatment for my (or my child/dependent/ward's) present condition and for any future conditions for which I seek treatment.

Signature____ **Date** _________________
(If under age 18, parent/guardian signature)

Revised: 1/21/2017, NewPatientHistoryForm

SHIMER CHIROPRACTIC, PC
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PATIENT INFORMATION

Patient Name: ____ (Age) ______ Gender: M F

Home Address: ____ Home Phone: ( ) ____________________

City, State, Zip: ____ Work Phone: ( ) ____________________

Email Address: ____ Cell Phone: ( ) ____________________

Do we Have your permission to send appointment reminders, health newsletters, and occasional promotions to your E-mail Address: [ ] Yes [ ] No

We will not sell or give your e-mail to any other agency.

Birth Date: _____ / _____ / ______ Marital Status: S M D W

Employer Name: _________________________ Work Address: ____

Emergency Contact: ____ Relation: ___________________________

Home Phone ( )____________________ Cell/Work Phone: ( )________________

How were you referred to this office? ____

Are you Medicare eligible? ( ) Yes ( ) No Medicare is 65 or more years old or disabled and the government put you on Medicare.

By signing below, I agree that the above information is accurate and true:

Patient Signature: ____ Date: ______________

AUTHORIZATIONS & FINANCIAL POLICIES:

A. At the patient's discretion, payment options are available after Doctor of Chiropractic has determined that chiropractic care is appropriate and has established a treatment plan.
B. I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payments of any and all services, covered or not covered. I understand I am responsible for all services rendered and must pay at the time of service. I understand that if I terminate my care and treatment, any fees for professional services rendered to me or under the contract cancellation policy will be immediately due and payable.
C. All patients acknowledge that they are financially responsible to remit payment in full for all services provided to them. All patients further understand and agree that we will not submit any billing data or related claim(s) for, or on, their behalf to any private insurance program, Medicare or any secondary Medicare Insurance Program carrier with whom they have insurance coverage.
D. We are required by law to provide you with the HIPAA NOTICE of PRIVACY PRACTICES that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice. By signing below I agree that I have been provided the opportunity to read and have a copy of the clinic HIPPA Notice of Privacy.
E. As a courtesy to you, our office will provide you a superbill if requested so you can turn it into your insurance company for possible reimbursement of services rendered at *Shimer Chiropractic, PC.* But as with all insurance plans, the superbill does not guarantee coverage of all or any services and fees. We will work with you to determine the amount of coverage and help estimate your responsibility.
F. All patients whose treatment visitation schedule that is considered "Wellness" or is once per month or less frequent may no longer be eligible for insurance assignment as this level of care is rarely covered by insurance. Our office offers numerous wellness plans to allow you to continue needed care.
G. We are required by the CO Board of Chiropractic Examiners that we notify you of our current fee schedule, possible fees incurred for accepting care, and your actual fee for exam, diagnostic evaluation, and treatment when you seek care through one of our promotions or advertisements. By signing below I agree that I have been provided the opportunity to discuss with the doctor or staff, read and have a copy of the clinic fee schedule and have been notified of my liability for services provided to me.

My Preferred Payment Option(s) (please indicate): [ ] Cash [ ] Visa [ ] MasterCard [ ] Discover [ ] American Express [ ] Debit [ ] FSA/HSA

By signing below I have read and agree with all of the above terms and policies.

Patient Signature: ______________________________________ ***Date:*** ____________

If patient is under 18 years of age: Parent/Guardian Signature: ______________________________________Date: ______________

Parent/Guardian Name (please print): ____

PATIENT CURRENT HISTORY

Name: ______________________________ Age: _______ Date of Birth: ____/____/_____ Gender: [] M [] F

Height: ____ft. ____in. Weight: _________ Occupation: ______________________ For how Long? ______________

1. Have you had Chiropractic care before? [] Yes [] NO If yes, how recently? _______________________
2. Reason for today's Visit: [] Pain []Discomfort []Stiffness []Maintenance care [] Recent Injury [] Previous Injury
3. When did your complaint (s) first begin? _________________________ Today, is the condition: [] Same [] Better [] Worse
4. How did it begin: [] Gradual [] Sudden [] Intermittently or Comes & Goes [] Unknown Describe: _____________________
5. What makes it Better: _______________________________ What makes it Worse: _________________________________
6. Have your experienced this/these complaint (s) before? [] Yes [] No

   If yes, when? ____

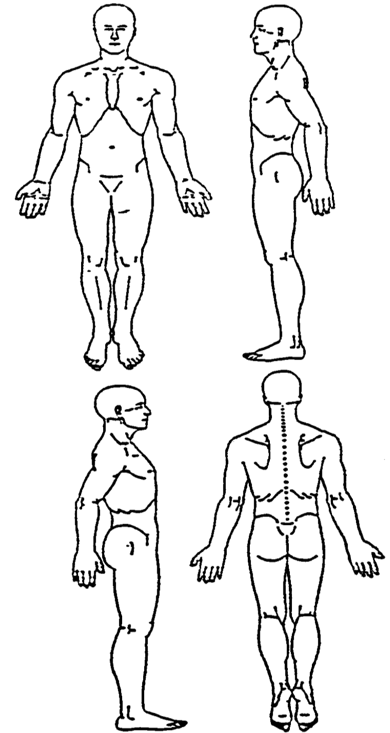
Where is/are your area(s) of complaint **TODAY**? (check all that apply)	Rate pain/ Discomfort between 0-10 (1 = minimal - 10 = severe/need to be hospitalized)	Check off all the types of pain and											frequency	
		Radiate/Travel	Sharp	Dull	Ache	Tingling	Numbness	Burning	Spasm	Throbbing	Shooting	Inflamed/ Swollen	Constant	Intermittent
Headache/ Migraine														
Neck														
Shoulder (s)														
Arm (s)														
Elbow (s)														
Wrist (s)														
Upper Back														
Middle Back														
Lower Back														
Hip (s)														
Sciatica														
Knee (s)														
Ankle (s)														
Other:														

Circle the area(s) causing you pain on the drawing below and label each by the type of pain.

A = Ache & Dull S = Stabbing & Sharp

B = Burning N = Numbness

P = Pins & Needles T = Tingling



7. Are you pregnant? [] Yes [] NO [] N/A If yes, how many weeks? _______________________
8. Are you currently experiencing any of the following: [] Double vision [] Rapid eye movement [] Blurriness [] Dizziness [] Numbness on one side of the face or body [] Fainting or lightheadedness [] Difficulty walking [] Difficulty speaking [] Headache or neck pain like you have never had before [] Difficulty swallowing [] Nausea or vomiting
   (If yes to any, please describe) ____

____ ________________________

(Patient/Legal Guardian Signature) (Date)

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PATIENT CURRENT HISTORY CONT.

1. **What Activities of Daily Living are affected by your symptoms/complaint(s):** (Check ALL that apply) [ ] Almost all activities [ ] My Daily Routine [ ] Standing [ ] Standing for long periods [ ] Sitting [ ] Sitting for long periods [ ] Going from Sitting or Lying to Standing [ ] Changing Positions [ ] Lying Down [ ] Walking [ ] Running [ ] Lifting [ ] Bending Over [ ] Getting out of Bed in morning [ ] Daily Personal Care [ ] Work Duties [ ] Driving [ ] Sleeping [ ] Hobbies [ ] Recreation/Sports Activities [ ] Concentrating [ ] Computer Work [ ] Daily Household Chores [ ] Getting Dressed [ ] Going Up/Down Stairs [ ] Reading [ ] Social Activities; Please explain or list others:____
____

2. Are you currently under medical or chiropractic care for this complaint(s)? [ ] Yes [ ] No
   If yes, Who have you seen for this complaint? ____
   What did they do? ____ How did you respond? _______________________________________

3. Are you currently under medical care for any other health condition? [ ] Yes [ ] No If yes, Please Explain: ___________________________________

4. **Have you had any changes in bodily functions since the condition began?** [ ] Yes [ ] No If yes, please check all that apply:

[ ] Balance	[ ] Bowel Habits	[ ] Breathing	[ ] Vision	[ ] Weakness	[ ] Grip Strength
[ ] Coordination	[ ] Urination	[ ] Coughing	[ ] Hearing	[ ] Fatigue	[ ] Weight Loss
[ ] Gait	[ ] Menstrual	[ ] Sneezing	[ ] Sexual Function	[ ] Temperature	[ ] Weight Gain

5. **Do you have any other complaints or concerns with your health?** ____
____
____

CHIROPRACTIC KNOWLEADGE ASSESSMENT

1. Did you know the absence of **pain** alone is not an indication of health? [] Yes [] NO

2. Did you know: pain has a cause and many times that cause **begins in the spine**? [] Yes [] NO

3. Did you know: over-the-counter pain medications/[prescriptions may only **mask the pain**? [] Yes [] No

4. Did you know: **your daily activities** can cause joint dysfunctions and pain in the spine and extremities? [] Yes [] No

5. Did you know: these joint dysfunctions can cause decreased joint motion and function in the body? [] Yes [] No

6. Did you know: decreased joint motion can also affect your ability to enjoy a **healthy and active lifestyle**? [] Yes [] No

7. Did you know: the health benefits of routine chiropractic care may include and of the following: 1) Improve nerve communication to body 2) improve joint motion 3) improve joint coordination 4) improve physical function 5) improved physical performance 6) improve posture 7) increase daily activity 8) provide pain and stress relief. [] Yes [] NO

HEALTHY LIFESTYLE - SOCIAL HISTORY

1. In general, would you say your health is: [ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor

2. Compared to one year ago, how would you rate your health in general now?
   - ☐ Much better now than one year ago
   - ☐ Somewhat better now than one year ago
   - ☐ About the same
   - ☐ Somewhat worse than one year ago
   - ☐ Much worse than one year ago

3. Where do you consider your health? [ ] Highest Priority [ ] High Priority [ ] Average Priority [ ] Low Priority [ ] Haven't thought about it.

4. Do you consciously exercise, eat nutritious meals, minimize stress and do things to maintain good health or improve your health? [ ] Yes [ ] No

5. Do you exercise? [ ] Yes [ ] No How often? 1X 2X 3X 4X 5X per week Other: ____
   What activities? [ ] Walking [ ] Jogging [ ] Weight Training [ ] Cycling [ ] Yoga [ ] Pilates [ ] Swimming [ ] Other: ___________________________

6. Do you smoke? [ ] Yes [ ] No How much? [ ] 1-5 cig/day [ ] 6-10 cig/day [ ] 1 pack/day [ ] > 1 pack/day: ____________________

7. Do you drink alcohol? [ ] Yes [ ] No How much / week on average? ____

8. Do you drink coffee/caffeinated drinks? [ ] Yes [ ] No How many cups / day? ____

9. Do you currently have a drug or substance abuse problem? [ ] Yes [ ] No If yes, discuss with doctor.

10. Are you currently smoking marijuana? [ ] Yes [ ] No How much? [ ] 1-5 x/day [ ] 6-10 x/day [ ] > 11 x/day: ______________________

HEALTHY LIFESTYLE - SOCIAL HISTORY CONT.

1. Please describe you Work.

Type: [ ] Professional [ ] Physical Labor [ ] Driver [ ] Clerical [ ] Factory [ ] Homemaker Other:_______________________________

Physical Demands: [ ] Heavy [ ] Moderate [ ] Mild [ ] Sedentary

Stress Level: [ ] High [ ] Medium [ ] Low

2. Do you currently take any **prescription or over-the-counter drugs or supplements**, i.e. vitamins, minerals, herbs? Please list below:

Name	Reason for taking	Name	Reason for taking

REVIEW OF SYSTEMS

1. Do you have skin, hair or nail problems? [ ] Yes [ ] No ____

2. Do you have mouth and/or throat problems? [ ] Yes [ ] No ____

3. Do you have nose and/or sinus problems? [ ] Yes [ ] No ____

4. Do you have ear problems? [ ] Yes [ ] No ____

5. Do you have eye problems? [ ] Yes [ ] No ____

6. Do you have chest or lung (breathing) problems? [ ] Yes [ ] No ____

7. Do you have heart and/or blood vessel problems? [ ] Yes [ ] No ____

8. Do you have blood or lymph node problems? [ ] Yes [ ] No ____

9. Do you have digestive problems? [ ] Yes [ ] No ____

10. Do you have genital problems (e.g. prostate, testicular, vaginal, uterus)? [ ] Yes [ ] No ____

11. Do you have urinary (including kidney or bladder) problems? [ ] Yes [ ] No ____

12. ***Females only (*males skip to question 13*)*: Do you have menstrual problems? [ ] Yes [ ] No ____

____

Have you ever taken birth control pills? [ ] Yes [ ] No Currently taking? [ ] Yes [ ] No How long : ____________________ yrs.

Are you now or is there a possibility you be pregnant? [ ] Yes [ ] No

Do you have any breast problems? [ ] Yes [ ] No ____

13. Do you have any nervous system diseases and/or mental health problems? [ ] Yes [ ] No ____________________________________

____

14. Do you have any gland and/or hormone problems? [ ] Yes [ ] No ____

15. Do you have any allergy or immunity problems? [ ] Yes [ ] No ____

16. Do you have any muscle, tendon or ligament problems? [ ] Yes [ ] No ____

17. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)? [ ] Yes [ ] No ____________________________

____

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PAST MEDICAL HISTORY

Musculoskeletal Conditions: (please check all conditions below that apply)

[] Headaches/Migraines
[] Neck Pain/Discomfort
[] Shoulder Pain/Discomfort
[] Upper Back Pain/Discomfort
[] Middle Back Pain/Discomfort
[] Low back Pain/Discomfort
[] Hip Pain/Discomfort
[] Sciatica
[] Elbow Pain/Discomfort
[] Wrist Pain/Discomfort
[] Knee Pain/Discomfort
[] Ankle Pain/Discomfort
[] Arthritis
[] Fused/Fixated Joints
[] Herniated Disc
[] Joint Replacement
[] Osteoporosis
[] Osteopenia

[] Inflammation/Swelling; Where: ____

Other Conditions:

[] Cancer
[] Tumors
[] Stroke
[] Seizure Disorders
[] High Blood Pressure
[] Pacemaker
[] Heart Disease
[] AIDS/HIV
[] Diabetes
[] Hepatitis
[] Tuberculosis
[] Hernia
[] Allergies: ______________________________
[] Other: ________________________________

1. Have you suffered any physical injuries, such as falls or blows, automobile accidents, whiplash, concussion or head trauma, lacerations, sprains, strains, dislocations, broken or cracked bones? [] Yes [] No If yes, list ALL, please describe: ____
____
____

2. List all surgeries or operations you have had (don't forget appendix, tonsils, ear tubes, vasectomy, hysterectomy):

1. ________________________________date:____________ 5.________________________________ date:____________
2.________________________________ date:____________ 6.________________________________ date:____________
3.________________________________ date:____________ 7.________________________________ date:____________
4.________________________________ date:____________ 8.________________________________ date:____________

3. Have you ever been Hospitalized for anything? [] Yes [] No If yes, list ALL and please describe: ______________________________________
____
____

FAMILY MEDICAL HISTORY

Please note any family history of the below conditions and note the relationship of relative.

M = Mother, F = Father, S = Sibling, ♀GP = Maternal Grandparent, ♂GP = Paternal Grandparent

[ ] Cancer: [ ] M [ ] F [ ] S [ ] ♀GP [ ] ♂GP
[ ] Diabetes: [ ] M [ ] F [ ] S [ ] ♀GP [ ] ♂GP
[ ] High Blood Pressure: [ ] M [ ] F [ ] S [ ] ♀GP [ ] ♂GP
[ ] Heart Disease: [ ] M [ ] F [ ] S [ ] ♀GP [ ] ♂GP
[ ] Arthritis: [ ] M [ ] F [ ] S [ ] ♀GP [ ] ♂GP
[] Stroke: [ ] M [ ] F [ ] S [ ] ♀GP [ ] ♂GP
[] Headaches: [ ] M [ ] F [ ] S [ ] ♀GP [ ] ♂GP
[] Spine or Back Disorders: [ ] M [ ] F [ ] S [ ] ♀GP [ ] ♂GP
[] Multiple Sclerosis: [ ] M [ ] F [ ] S [ ] ♀GP [ ] ♂GP
[] Psychological Disorders: [ ] M [ ] F [ ] S [ ] ♀GP [ ] ♂GP

Are there any other diseases or conditions that are common among your family members, i.e. inherited diseases or conditions? [ ] Yes [ ] No
Describe:____
____
____
____

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HEALTH CONDITIONS

Abnormal postural habits or distortions of our bodies are the result of trauma, stress, unbalanced muscles and the affect of gravity on our bodies. When any part of our body becomes misaligned and unbalanced from its normal position, this will cause stress to the nervous system and structures of our body. These imbalances cause poor or abnormal biomechanics within the joints of our bodies. This alteration of biomechanics not only stresses the nervous system but weakens the physical structures of our body leaving us more prone to injury and degeneration. It has been extensively documented that abnormal joint biomechanics, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Posture, a “hunched forward” posture starting in the neck and progressively moving down your spine weakening the entire body.

Our bodies are one complete integrated system; any injury to our foot will affect our knee, hip and spine. A neck injury such as whiplash can affect our entire body. Please review the health conditions below and identify which condition or symptom you are currently experiencing (current is defined within the last 3 to 6 months) or you have experienced in the past (longer than 6 months ago).

Check the box next to “C” for current condition, “P” for past condition, or you may check both boxes.

CERVICAL SPINE (NECK) including the upper extremity:

Postural distortions (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience…?

[ ] C [ ] P Neck pain
[ ] C [ ] P Neck stiffness
[ ] C [ ] P Neck lump or mass
[ ] C [ ] P Headaches: stress
[ ] C [ ] P Headaches: migraine
[ ] C [ ] P Pain into your shoulders/arms/hands
[ ] C [ ] P Numbness/tingling in arms/hands
[ ] C [ ] P Weakness in grip
[ ] C [ ] P Coldness in hands
[ ] C [ ] P Eye pain
[ ] C [ ] P Visual disturbances
[ ] C [ ] P Eye redness or discharge
[ ] C [ ] P Dry eyes
[ ] C [ ] P Dizziness
[ ] C [ ] P Loss of balance
[ ] C [ ] P Spinning sensation or vertigo
[ ] C [ ] P Ear pain
[ ] C [ ] P Ringing in ears
[ ] C [ ] P Hearing loss or disturbance
[ ] C [ ] P Ear discharge
[ ] C [ ] P Thyroid conditions
[ ] C [ ] P Sinusitis
[ ] C [ ] P Loss of smell
[ ] C [ ] P Allergies/hay Fever
[ ] C [ ] P Nasal discharge
[ ] C [ ] P Recurrent colds/flu
[ ] C [ ] P Low energy/fatigue
[ ] C [ ] P TMJ/pain/clicking
[ ] C [ ] P Bad breath
[ ] C [ ] P Loss of taste
[ ] C [ ] P Loss of touch sensation
[ ] C [ ] P Stroke or TIA

THORACIC SPINE (UPPER BACK):

Postural distortions in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…

[ ] C [ ] P Chest pain
[ ] C [ ] P Heart palpitations
[ ] C [ ] P Heart murmurs
[ ] C [ ] P Tachycardia
[ ] C [ ] P Heart attacks/angina
[ ] C [ ] P Fainting
[ ] C [ ] P Fatigue
[ ] C [ ] P Swelling in the legs
[ ] C [ ] P Changes in skin color
[ ] C [ ] P Heart valve problems
[ ] C [ ] P Recurrent lung infections/bronchitis
[ ] C [ ] P Asthma/wheezing
[ ] C [ ] P Shortness of breath
[ ] C [ ] P Pain on deep inhalation/Exhalation
[ ] C [ ] P Frequent/chronic cough
[ ] C [ ] P Phlegm/expectorant
[ ] C [ ] P Coughing up blood (Hemoptysis)
[ ] C [ ] P Blue skin (Cyanosis)

THORACIC SPINE (MID BACK):

Postural distortions in the mid back will weaken the nerves into your ribs/chest, urinary and upper digestive tract, and affect these parts of your body. Do you experience…

[ ] C [ ] P Mid back pain
[ ] C [ ] P Pain into your ribs/chest
[ ] C [ ] P Abdominal pain
[ ] C [ ] P Indigestion/heartburn
[ ] C [ ] P Reflux
[ ] C [ ] P Nausea
[ ] C [ ] P Ulcers/gastritis
[ ] C [ ] P Cramping
[ ] C [ ] P Bloating/abdominal distention
[ ] C [ ] P Hypoglycemia
[ ] C [ ] P Tired/irritable after eating or when you haven’t eaten for a while

LUMBAR SPINE (LOW BACK):

Postural distortions in the low back will weaken the nerves into your legs/feet, lower digestive tract, urinary and pelvic organs and affect these parts of your body. Do you experience…

[ ] C [ ] P Low back pain
[ ] C [ ] P Pain into your hips/legs/feet
[ ] C [ ] P Numbness/tingling in your legs/feet
[ ] C [ ] P Coldness in your legs/feet
[ ] C [ ] P Muscle cramps in your legs/feet
[ ] C [ ] P Weakness/injuries in your hips/knees/ankles
[ ] C [ ] P Constipation
[ ] C [ ] P Diarrhea
[ ] C [ ] P Pain during urination
[ ] C [ ] P Recurrent bladder infections
[ ] C [ ] P Change in frequency of urination
[ ] C [ ] P Change in urine flow
[ ] C [ ] P Change in urine color
[ ] C [ ] P Kidney stones
[ ] C [ ] P Menstrual irregularities/cramping (females)
[ ] C [ ] P Sexual dysfunction
[ ] C [ ] P Genital itching
[ ] C [ ] P Rectal bleeding

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HIPPA Notice of Privacy Practices

Effective Date: January 2017

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 THIS INFORMATION CAREFULLY.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Our Privacy Pledge

We have always and will always respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

Permitted Uses And Disclosures Without Your Consent Or Authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1) We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
2) We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4) We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
5) We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

Our Duties

We are required by law to maintain the privacy and security of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.
We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement, we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.
We are required by law to notify you if we are unable to agree to a requested restriction.

The Methods in Which We May Uses and Disclosures Medical Information About You

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

1) For treatment. Your Doctor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2) For payment. We will use and disclose medical information about you so that payment for the treatment you receive may be collected from you or another party.
3) For practice operation. Your Doctor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4) For contacting you and appointment reminders. Your chiropractor(s) and members of the practice staff may need to use your name, address, phone number, text, e-mail, and your clinical records to contact you with notifications, text, messages, birthday and holiday relates messages, billing inquires, to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to your. 164.520 (b)(1)(iii) (A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine.
5) For health care operations. We may use and disclose medical information about you for our office operations. These and disclosures are necessary to run the clinic in an efficient manner and provide that all patients receive quality care. For example, your medical records may be used in the evaluation of services, and the appropriateness and quality of chiropractic treatment we provide. Chiropractic services will be provided in an open room where other patients are also receiving care. Other persons in the office may overhear some of your protected medical information during the course of care. Should you need to speak with the doctor at any time in private, a place for these conversations will be provided upon request. To the extent permitted by law, we may use cameras or other recording devices in our clinic. The clinic will have notice posted at the clinic informing you of the use of such devices.
6) As required by law. We will disclose medical information about you when required to do so by federal or state laws or regulations.
7) Health oversight activities. We may discuss medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. The activities are necessary for government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
8) Lawsuits and disputes. If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
9) Law enforcement. We may release medical information if asked to do so by a law enforcement official in response to a court or subpoena.
10) Electronic disclosure. We may use and disclose your medical information electronically. For example, your medical information is maintained on an electronic health record. If another provider requests a copy of your record for treatment purposes, we may forward such record electronically.

Disclosures Requiring Authorization

1) **Marketing**: Marketing generally includes a communication made to describe a health-related product or service that may encourage you to purchase or use the product or service. We will obtain your written authorization to use and disclose your medical information for marketing purposes unless the communication is made face-to-face, involves a promotional gift of nominal value, or otherwise permitted by law. *All other uses and disclosures of your information for marketing purposes require your written authorization. You have the right to revoke such authorization in writing.*

SHIMER CHIROPRACTIC, PC
Adjust. Align. Shine.

HIPPA Notice of Privacy Practices Cont.

Your Rights Regarding Your Medical Information

You have the following rights regarding medical information collected and maintained about you.

1) **Your right to revoke your authorization**. You may revoke your authorization to us at any time; however, our revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:
    a. If we have already released your health information before we receive your request to revoke your authorization.164.508*b)*5)(i)
    b. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization please write to us at Shimer Chiropractic, PC, 2330 N. Main Street, Unit A, Longmont, CO 80501.
2) **Your Right to Limit Uses or Disclosures.** If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.
3) **Your Right To Receive Confidential Communication Regarding Your Health Information.** We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.
4) **Your Right To Inspect And Copy Your Health Information.** You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files.
5) **Your Right To Amend Your Health Information.** You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.
6) **Your Right To Receive An Accounting Of The Disclosures We Have Made Of Your Records.** Colorado law requires that we furnish you, upon your request, a copy of any information related in any way to you, which we have transmitted, to any company, or any public or private agency, or any person.
    a. You may charge reasonable copying charges for this service which are set forth in the statues as well as a handling charge and actual postage.
    b. We may deny access to a record if we reasonably conclude that knowledge of the information contained in the record would be injurious to the health or welfare of the patient or could reasonably be expected to endanger the life or safety of any other person.
7) **Your Right To Obtain A Paper Copy Of This Notice.** If you have agreed to receive privacy notices by e-mail, you may request a paper coy of this notice at any time.
8) **Re-Disclosure.** Information that we use or disclose may by subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.
9) **Your Right To Complain.** You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and we will not take any action against you if you file a complaint. You may make an oral or written complaint at any time with our practice manager or directly to the Secretary of Health and Human Services.
10) **Uses or Disclosures Not Covered.** Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

By signing below I agree that I have read and agree with all of the above terms and policies and that a copy will be made available, if I request one.

Patient Signature:**____** ***Date:*****__________________**

If patient is under 18 years of age: Parent/Guardian Signature: _______________________________ Date: ______________

Parent/Guardian Name (please print): ____

Please print this form, complete the form and bring it with you to your first appointment.