Confidential Patient Health Record

DATE	I.D. NO.

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ State _____ Zip Code: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: ☐ M ☐ F

Cell Phone: _____ E-mail Address: _____

Social Security # _____ Driver's License Number: _____

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Business Employer: _____ Type of Work: _____

Business Phone: _____

Name of Spouse _____ Spouse's Social Security # _____

Spouse's Employer _____ Business Phone _____

Type of Work _____ Name and Ages of Children _____

Referred To This Office By: _____ _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who Is Responsible For Your Bill, You and ☐ Spouse ☐ Workers' Comp. ☐ Auto Insurance ☐ Medicare ☐ Medicaid

☐ Personal Health Insurance (Name) _____ ☐ Health Card # _____

Insured Person's Name _____ Date of Birth _____

CURRENT HEALTH CONDITION

Unwanted Health Condition _____

Other Doctors Seen For This Condition: ☐ Yes ☐ No ____ Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? ☐ Yes ☐ No

Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____

Date of Accident: _____ Time of Accident: _____

Have You Made A Report of Your Accident To Your Employer: ☐ Yes ☐ No

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine

☐ Insulin ☐ Other _____

Do You Wear A Shoe Lift? ☐ Yes ☐ No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

_____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other _____

Major Accident or Falls: _____

_____

Hospitalization (Other Than Above): _____

_____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE

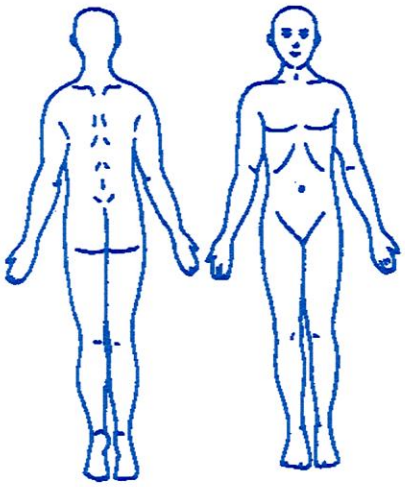
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FEMALES ONLY:

When was your last period?_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

_____

Doctor's Signature

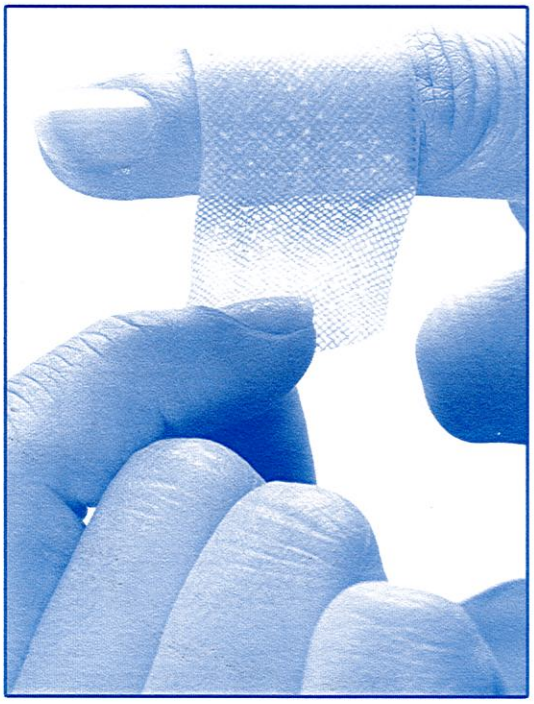
Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Check here if you want the Doctor to select the type of care appropriate for your condition

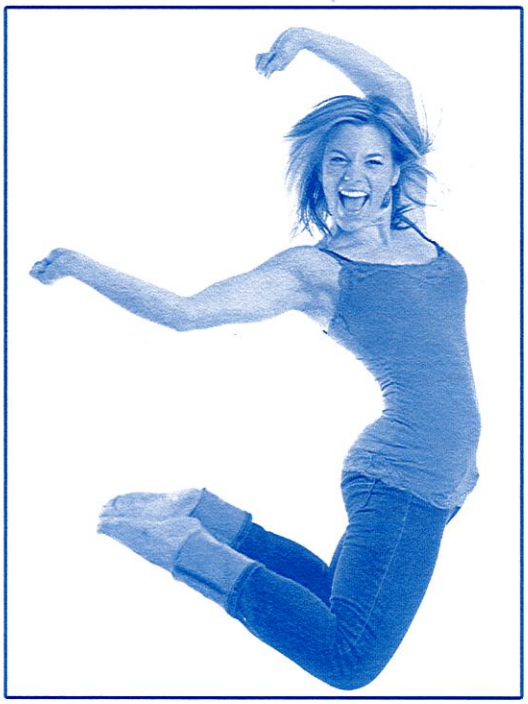
Date _____ Patient's Signature _____

If this is an accident related injury, please fill out the Accident Form. Thank You!



Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature _____ *Date* _____

Consent to Treat a Minor _____ *Date* _____

Guardian or Spouse's Signature of Authorizing Care _____ *Date* _____

west plains Wellness
Chiropractic Massage Rehabilitation Weight Loss

DR. Keith E. Schulz, JR., DC, CCST

12727 W. 14th Ave.
Airway Heights, WA 99001
Ph: 509-244-4818
Fax: 509-244-8945

HIPAA - NOTICE OF PRIVACY PRACTICE SUMMARY

-This summary discloses how health information about you may be used. A full notice of your privacy rights will be provided to you upon your request.

-West Plains Wellness uses health information about you for treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of care that you receive.

-West Plains Wellness values your privacy and will not disclose your personal information without your written permission, or unless the law authorizes or requires us to do so.

-You have the right to see your medical records at any time. You must provide a written request to obtain a copy of your medical records. West Plains Wellness reserves the right to charge for these copies per Washington State Law and will provide copies in a timely manner.

-You may amend your medical records with a written request.

-You may file a written complaint to Chani Brooks and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

-West Plains Wellness must maintain the privacy of protected health information (PHI), provide you with notice of its legal duties and privacy practices with respect to your health information and abide by the terms of the notice.

-If you have any questions about your protected health information (PHI), please contact Chani Brooks at 509-244-4818.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices in one of these formats:

- **I have been provided a Hard Copy of the Notice of Privacy Practices (NPP)**
- **I have been given an electronic version sent to my email listed below:**

  _____

- **I do not need a copy at this time, but I may ask for one at any time.**

_____ Date_____

Signature of Patient or authorized representative

_____

Printed name if signed on behalf of patient/ Relationship (parent, legal guardian, personal representative, etc.)

This form will be retained in your health record.

Missed Appointment Policy for ALL West Plains Wellness Services

It is vital to your care that you keep all your appointments, with the exception for emergencies. Appointment printouts or text/email reminders are provided to help you save the date. If you need to reschedule an appointment, please call our office and arrange for a make-up appointment. In the instance of a last minute/rescheduled appointment or a **NO SHOW** without notice by phone or email (**less than 24 hours of your scheduled appointment time**), we reserve the right to charge you a **$50 No Call/ No Show Fee** for **Chiropractic Appointments** and **$25 for Massage Therapy** Appointments.

If you are currently being treated under an open Motor Vehicle claim or Worker's Comp claim, **this fee WILL NOT be billed to your insurance,** or on behalf of your claim for Motor Vehicle Accident and/or Worker's Comp. **You will be personally responsible for this fee.**

Printed Name_____

Signature_____

Date_____

Permission to Verbally Discuss Protected Health Information

—Completion of this form is optional—

Patient name	Date of birth	Claim Number	
Patient street address	City	State	Zip
Cell/ Home phone	Email		

I give permission to West Plains Chiropractic (DBA West Plains Wellness) to VERBALLY discuss the following medical and billing information about me *(check all boxes that apply)*:

- ☐ Scheduling/Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Chemical dependency information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Lab/test results
- ☐ Billing and payment information
- ☐ Other (describe):_____

WPC/WPW has my permission to discuss the above information with:

1 Name _____

Street address _____

City, State, Zip _____

Home phone _____ Work phone_____

2 Name _____

Street address _____

City, State, Zip _____

Home phone _____ Work phone_____

I understand that I have the right to revoke my permission at any time except where WPC/WPW has already made disclosures in reliance upon this request. **I understand that I must notify WPC/WPW in writing if I want to revoke my permission.**

Date _____

Signature of Patient/Authorized Representative X _____

If authorized representative, please sign and attach copies of supporting legal documentation.

Reason patient unable to sign _____

NOTE: For copies of medical records, contact 509-244-4818.

—Information sheet on back—

Permission to Verbally Discuss Protected Health Information - Information Sheet

—Completion of this form is optional—

West Plains Chiropractic, P.S. (DBA West Plains Wellness) knows that privacy regulations have an impact on our customer service to you, especially when it comes to discussing information about you with family, friends and others you designate who are involved in your care. We have established a process that allows you to tell us who we may talk with about your medical care. This includes appointment and scheduling information, lab and test results, treatment information and billing information.

How can I give others permission to get verbal information about me?

Complete the Permission to Verbally Discuss Protected Health Information form on the reverse side of this page to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information.

How is the information on the form used?

Anytime your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this might be useful?

- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping an elderly patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parent's appointment time

Can the person I designate also get copies of my medical records?

No, they can only receive verbal information. To get copies of medical records, you must complete a separate Authorization form available at our clinics, by calling 509-244-4818.

What if I change my mind?

You can change or revoke (stop) this process at any time by writing to us at the address shown below. Forms are available at your clinic.

What happens if I don't complete this form?

We will continue to protect your private health information as required by law.

Where do I send the completed form or any changes?

Mail to:
West Plains Wellness
Release of Information
12727 W 14th Ave.
Airway Heights, WA
99001

OR fax to:
509-244-8945

Call 509-244-4818 with questions.