Life Chiropractic

Name: _____ Employer: _____
Address: _____ Address: _____
City/State: _____ City/State: _____
Zip Code: _____ Zip Code: _____
Home Phone #: ( )_____-_____ Work Phone: ( )_____-_____ Extension____
Cell Phone #:( ) _____-_____ Email: (For News letter) _____
Social Security #: _____ Driver's License #:_____ Age:____
Date of Birth: _____ Single_____ Married_____ Other_____
Facebook Yes_____ No_____

Contact in case of Emergency: Name: _____Relationship:_____
Address: _____
Phone #: ( )_____-_____

Health problem for which you came to this office: _____
Is condition related to: (Please Circle) Employment Auto Accident Other_____
Date Symptoms first occurred: _____
Have you ever had same or similar symptoms? **N** or **Y** Date:_____
Lost work time: **N** or **Y** Date returned to work: _____
Other Doctors you have seen for this problem: _____
Were you Hospitalized? **N** or **Y** If so, where: _____
Have you received Chiropractic care before? **N** or **Y** If so, where: _____

How did you hear about our office?
HMO____ PPO____ TV___ Sign____ Lecture____ Website____ Other_____
Personal referral(name) _____

Primary Physician's Name: _____

PLEASE READ, SIGN AND DATE
I authorize Life Chiropractic to bill my insurance company for charges incurred.
I authorize Life Chiropractic to release medical information requested by the insurance company with regard to my claims filed on my behalf.
I understand that I will be responsible for charges denied by my insurance company.

Signature_____ **Date**_____

CONFIDENTIAL HEALTH HISTORY

THE ITEMS BELOW MAY RELATE TO YOUR CURRENT CONDITION. MARK WITH A CHECK IF YOU HAVE EVER HAD THE PROBLEM.

GENERAL
___Fever
___Chills
___Night Sweats
___Loss of Sleep
___Fatigue
___Nervousness
___Weight Loss or Gain
___Allergies
___Bleeding Problem
___Anemia
___Diabetes
___Cancer
___Thyroid Disease/Goiter
___Alcoholism
___Drug Abuse
___Any Surgeries
___Any Medications
___Any Supplements/Vitamins

EYE EAR NOSE THROAT
___Poor Vision
___Pain in Eyes
___Deafness
___Nose Bleeds
___Sinus Troubles
___Dental Problems
___Hoarseness
___Tonsillectomy

GASTROINTESTINAL
___Poor Appetite
___Difficulty swallowing
___Belching or Gas
___Frequent Nausea
___Vomiting
___Vomiting Blood
___Pain over Abdomen
___Ulcer
___Black or Bloody Stool
___Liver Problems
___Gall Bladder Problems
___Jaundice
___Hernia
___Diarrhea
___Constipation
___Hemorrhoids
___Appendicitis

RESPIRATORY
___Difficulty breathing
___Chronic breathing
___Spitting Phlegm
___Spitting Blood
___Wheezing Asthma
___Pneumonia
___Tuberculosis

CARDIOVASCULAR
___Stroke
___Irregular Heartbeat
___High Blood Pressure
___Pain Over Heart
___Ankle Swelling
___Varicose Veins
___Rheumatic Fever

GENITOUNIARY
___Frequent Urination
___Painful Urination
___Blood in Urine
___Kidney disease
___Inability to control urination
___Difficulty starting urine flow
___Get up _____times per night to urinate
___Breast Lump or Pain
___Venereal Infection
___Sexual Difficulties

WOMEN ONLY
___Hot Flashes
___Painful Periods
___Excessive Flow
___Irregular Cycle
___Vaginal burning or itching
___Date Last Period Began
___Date of Last Pap test

MEN ONLY
___Testicular swelling
___Prostate Problems

NEUROLOGIC
___Weakness
___Twitching
___Tremors
___Headache
___Fainting
___Dizziness
___Convulsions
___Epilepsy
___Numbness/tingling
___Arm/Leg pain
___Mental Disorder

SKIN
___Itching
___Bruising easily
___Skin Cancer
___Change in Mole

MUSCULOSKETAL
___Neck Stiffness/Pain
___Pain Between Shoulders
___Low Back Pain
___Swollen Joints
___Painful Joints
___Muscle Aches/Soreness
___Spinal Curvature
___Arthritis
___Any Fractures

HABITS
___Drinking
___Smoking
___packs per day
___Recreational Drug Use

EXERCISE
___None
___1-2 times per day
___3-5 times per day
___6-7 times per day

FAMILY HISTORY
___Muscle, bone or nerve
___Diabetes
___Thyroid Disease
___Tuberculosis
___High Blood Pressure
___Heart Disease
___Kidney Disease
___Cancer

Name: **Date:**

Consent for Chiropractic Treatment and Acknowledgment of Receipt of Information

To the patient: Every type of health care is associated with some risk of a potential problem. Health care providers, including chiropractors, are required by law, to tell you the nature of your condition, the general nature of the treatment, the risks involved, and the reasonable therapeutic alternatives.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. Please read this form carefully. Ask about anything you do not understand, and we will be pleased to explain it.

In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities. Although our occurrence is extremely remote, some risks are known to be associated with these procedures. These include:

1) Stroke: Stroke is the most serious problem associated with spinal manipulation. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery (located in the neck vertebrae). This problem occurs so rarely that there is no conclusive data to quantify probability.
2) Disc herniations: Disc herniations that create pressure on the spinal nerve or spinal cord are frequently successfully treated by chiropractors. Rarely, treatment may aggravate the problem, resulting in increased low back pain, and numbness of a transient nature. Residual may last for a few days but seldom for longer periods of time.
3) Soft tissue injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, treatment may injure some muscle or ligament fibers. The result is temporary increase in pain and necessary treatments for resolution, but there are no long-term affects for the patient.
4) Rib fractures: The ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients carefully, especially those who have indications of osteoporosis on their x-rays.

----------CONSENT----------

I hereby authorize and direct Dr. Rehkopf, together with associates and assistants of his choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulation/ adjustment, various modes of physical therapy, x-rays and any additional procedures or services that may be deemed necessary or reasonable. This treatment has been explained to me, and alternative methods of treatment (if any) have also been addressed. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I have had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

Patient's name_____ Date_____ Time_____

Signature of patient, parent or guardian _____

Relationship to patient _____

I certify that I have provided and explained the information set forth herein, including any attachments, and have answered all questions concerning proposed treatment to the best of my knowledge and ability.

Signature of Chiropractic physician_____ **Date**_____ **Time**_____

Appointment Reminders and Health Care Information Authorization

Dr. Rehkopf and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, authorizations, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. We will also attempt to reach you at work. If necessary, we will also attempt to reach you on your cell phone, pager and email. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released, or you may revoke your authorization to us at any time. However, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health insurance if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us, may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you, or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient name printed Date

_____ _____

Patient signature Authorized provider representative

_____ _____

Personal representative printed Personal representative signature

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Description of personal representative's authority to act for the patient.

Chiropractic Association of Louisiana Authorization

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Chiropractic Association of Louisiana (CAL). This disclosure will be made if we need the CAL's assistance to receive reimbursement for your services, or we need the CAL's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form you are giving us authorization to send the CAL this information. You are also giving the CAL authorization to re-disclose your information to the party responsible for the payment of your services, the CAL's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

You may restrict the individuals or organizations to whom your health information is released or revoked your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization.

Information that we use or disclosed based on the authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we may send to the CAL at any time (164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient name printed Date

_____ _____

Patient signature Authorized Provider Representative

_____ _____

Personal representative printed Personal representative Signature

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Description of personal representative's authority to act for the patient.

_____Clinic Name

Notice of Privacy Practices for Protected Health Information

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.

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

Your chiropractor 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.

Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer if they are potentially responsible for the payment of your services.

Your chiropractor 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.

Your chiropractor and member of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, insurance authorizations, information about treatment alternatives, or other health related information that may be of interest to you. 164.520(b)(1)(iii)(A). If you are not at home to receive an appointment reminder etc., a message will be left on your answering machine. Likewise, we may try to contact you at work, on you cell phone, beeper or email address.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

Our Privacy Pledge

We have and always will 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 organizations.

Permitted uses and disclosures without your consent and 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 judgement we believe that you intend for us to provide care.

Under 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.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization. 164.508(b)(5)(I)
2. 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

4416 Trenton St.
Metairie, LA 70006

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.

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.

Your right to inspect and copy your health information

You have the right to inspect and /or copy your health information for six years from the date that the record was created or as long as the information remains in our files.

Your right to amend your health information

You have the right to request that we amend your health information for six 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 your to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

Louisiana 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.

We may charge reasonable copying charges for this service which are set forth in the statues as well as handling charges and actual postage.

We may deny access to a record if we reasonable conclude that knowledge of he 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.

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 copy of this notice at any time.

Our duties

We are required by law to maintain the privacy 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.

Re-disclosures

Information that we use or disclose 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.

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 will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

Life Chiropractic

4416 Trenton St.
Metairie, LA 70006

To Contact Us

If you would like further information about our privacy policies and practices please contact Life Chiropractic

4416 Trenton St.
Metairie, LA 70006
504-885-8899

This notice is effective as of _____. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

_____ _____
Patient Name printed Date

_____ _____
Patient signature Authorized provider representative

_____ _____
personal representative printed personal representative signature

Description of personal representative's authority to act for the patient.