

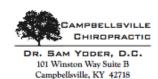
Date:_____



Electronic Health Records Intake Form

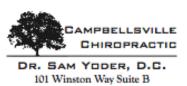
In compliance with requirements for the government EHR incentive program Last Name:_____ First Name: Email address: ______@____ Phone Number _____ Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail Gender (Circle one): Male / Female Preferred Language: Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked Amount Smoked (packs/day): Years Smoking: CMS requires providers to report both race and ethnicity Social Security Number:___ Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer Are you currently taking any medications? (Please include regularly used over the counter medications) Dosage and Frequency (i.e. 5mg once a day, etc.) **Medication Name** Do you have any medication allergies? **Medication Name** Reaction Onset Date Additional Comments ☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____



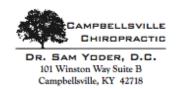
Do you currently have or have you ever had (all questions must be answered): High blood pressure? Yes No \square High cholesterol? Yes No \square Diabetes? No \square Yes A heart attack? Yes 🗌 No A stroke? Yes No High blood pressure? Yes No High cholesterol? Yes \square No \square Known heart disease? Yes No 🗌 Rheumatic heart disease? Yes No Yes \square No \square A heart murmur? Chest pain with exertion? Yes No \square Irregular heart beat or palpitations? Yes \square No \square Lightheadedness or do you faint? Yes No Unusual shortness of breath? Yes No Yes No No Cramping pains in legs or feet? Emphysema? Yes No Other metabolic disorders (thyroid, kidney, etc.)? Yes No Epilepsy? Yes No Asthma? Yes No Back pain: upper, middle, lower? Yes No No Other joint pain (explain on back of form)? Yes No Muscle pain or an injury (explain on back of Form)? Yes No 🗌 Have parents who died from a stroke, heart attack, or cancer: Yes No \square To the best of my knowledge, the above information is true. Signature _____

Witness



Campbellsville, KY 42718

Name		
☐ Check if you would like Dr. Yoder's N	Monthly Newsletter on Health Tips, Info	rmation, & Promotions via email (1-2 x month)
How did you hear about this	s office?	
Friend	Internet (website)	Other
Referral from other Doctor		Advertisement (type)
Name of Person Responsible for Paymer I understand and agree that health and a As such, I authorize any charges for serv Campbellsville Chiropractic, LLC. Furthe forms to assist me in making such collect by my insurance company is to be paid of However, I clearly understand and agree	Name of Insurance Company	ment between an insurance carrier and myself by to be paid directly to the office of fice will prepare any necessary reports and I agree that any amount authorized to be paid
Patient's Signature Guardian or Spouse Signature		
Juanulan of Spouse Signature		



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

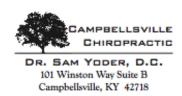
I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who
 may be involved in that treatment and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name (Print):	Relationship to the Patient:	
Signature:	Date:	



Date

All health care professionals including medical doctors, osteopathic doctors, chiropractic doctors and physical therapists		
that perform manipulation (adjustments) are required by law to obtain your informed consent before initiating treatment		
I,, do hereby give my consent to the performance of conservative, noninvasive treatment to the joints and soft tissue. I understand that the procedures may consist of manipulations (adjustments) involving movement of the joints and soft tissue. Therapeutic exercise, ultrasound, hot packs (or ice), TENS units and other therapeutic modalities may also be used.		
Risks: Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are risks and complications associated with these procedures as follows:		
Soreness: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments.		
Dizziness: Temporary symptoms like dizziness can occur but are relatively rare.		
ures/Joint Injury: I further understand that in isolated cases of underlying physical defects, deformities, or blogical processes such as weak bones from disease, cancer or osteoporosis may render the patient susceptible to v.		
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur between once per million to once per ten million treatments.		
General Modalities: hot packs, ice packs and other adjunctive therapies used in tissue healing can, if used inappropriately, cause discomfort such as burns or pain. If this were to occur I understand that it should be reported to the doctor.		
Positive Treatment Results: I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.		
Alternative Treatment: Reasonable alternatives to these procedures have been explained to me including rest, home therapy, over the counter medication, medical consultation, surgery and the absence of treatment altogether.		
I have read or have had read to me the above explanation of chiropractic treatment. Any questions I had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.		
Date Patient Signature		

Witness Signature