Advanced Chiropractic and Massage
46175 Westlake Drive, Suite 200,
Sterling, VA 20165 (703)444-1182

Date: _____

Personal Information

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____
Cell Phone: _____
Cell Phone Carrier (for Text Messaging): _____
Email: _____
Contact Preference: ☐ Home # ☐ Cell # ☐ Text ☐ Email
****For confidential correspondence, please create a Secret Question (i.e., What was my first pet's name?)**
Secret Question: _____
Secret Answer: _____
Preferred time(s) for an appt? _____
Social Security: _____
Birthdate: _____ Sex: _____
Race: _____ Hispanic or Latino: ☐ Yes ☐ No
Preferred Language: _____
Marital Status: _____
Spouse's Name: _____
Who may we thank for referring you: _____

Emergency Contact

Name: _____ Relationship: _____
Phone #: _____

Employer Information

Employer: _____
Address: _____
Phone #: _____
Occupation: _____
Spouse's Employer: _____
Spouse's Birthday: _____ SSN # _____

Insurance Information

Subscriber: _____
Relationship to Patient: _____
Insurance Company: _____
ID Number: _____

Does the patient have Secondary Insurance: ☐ Yes ☐ No
Subscriber: _____
Relationship to Patient: _____
Insurance Company: _____
ID Number: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the insurance company(ies) named above and assign directly to Advanced Healthcare, P.C./ Tim Scheuerman, D.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Advanced Healthcare, P.C. / Tim Scheuerman, D.C. may use my health care information and may disclose such information to the insurance company(ies) named above and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. I understand that certain procedures that the doctor may deem necessary may not be covered by my insurance, and that I will be responsible for these charges.

_____
Patient Signature Date

Financial Agreement

To the best of my knowledge, the information provided to this office is complete and accurate. I acknowledge that all charges incurred in this office are my responsibility. I understand that payment is due at the time of my visit. I understand that if my account remains unpaid by me for a period of 90 days, it may be referred to an agency or attorney for collection. I understand that should my account be placed for collection, I will be responsible for all costs incurred, including 33.3% attorney's fees and interest at 1.5% per month (18% annum).

_____
Patient Signature Date

The Federal Government suggests that you apply for a Microsoft Health Vault account. The high cost of this vault will increase the cost of your care resulting higher fees. Or you can request your records for free and we will send them to you via Secure Email, Fax or USPS mail.

☐ I would prefer **NOT** to apply for the Microsoft Health Vault

☐ I want to apply for the Microsoft Health Vault

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Patient Name: _____ Date: _____

1. Purpose of appointment _____

2. How often do you experience your symptoms?
☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

3. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

4. How long have you had this problem? _____

5. How do you think your problem began? _____

6. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No

7. What aggravates your problem? _____

8. What relieves your problem? _____

9. Name & phone # of your Primary Care Physician: _____

10. Name & phone # of the doctor(s)/ healthcare professional(s) seen for this condition?

_____

11. How would you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

12. What type of exercise do you do? ☐ Strenuous ☐ Moderate ☐ Light ☐ None

13. Date of last: Physical Exam _____ Spinal Exam _____ Spinal X-ray _____
Chest X-ray _____ MRI/ CAT Scan _____ Urine Test _____ Blood Test _____

14. List any diseases and/ or conditions that run in your immediate family and PLEASE NOTE WHO HAD IT:

_____

15. List all surgical procedures, hospitalizations, serious illnesses you have had:

_____

16. Fractures and dislocations: _____

17. Anything else pertinent to your visit today? _____

Patient Signature

_____

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert A Serious Threat To Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death Or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or health care operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a health care item or service for which you have paid us out-of-pocket in full.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice. *You have the right* to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Patient Acknowledgment

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____

Patient Signature

Date _____ / _____ / _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

Effective Date:_____

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability And Accountability Act) enacted to protect the confidentiality of your health information. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting health care operations, and as otherwise described in this notice.

How your HEALTH INFORMATION may be used To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with medical care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between health care providers and business office staff. In addition, we may share your health information with other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern health care can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interests.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.