



## Initial Visit Form

### GENERAL INFORMATION (all clients fill out)

#### Patient Information:

Last Name	First Name	MI	Today's Date	
Street address (No PO Box)			How did you hear about us?	
City	State	Zip	Social Security #	Driver's License #
Home Phone		Sex	Marital Status	Date of Birth
		M F	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Div. <input type="checkbox"/> Wid.	
Work/Cell Phone		Emergency Contact Name/Phone #		

#### Insurance Information:

Name of Insured	Date of Birth	Date injury occurred (date of accident)
Your Relationship with Insured		Policy #                      Claim # / ID #
Insurance Company Name		Accident/Injury type (choose one)
Insurance Claims/Billing Address		<input type="checkbox"/> work (please explain):
City                      State                      Zip		<input type="checkbox"/> motor vehicle accident
		<input type="checkbox"/> other (please explain):

### MEDICAL HISTORY (all clients fill out)

1. When was your last physical exam? \_\_\_\_\_ Who performed it? \_\_\_\_\_  
 Do not recall when I had my last physical exam
  
2. Have you had any previous accidents/traumas/falls? **Yes/ No/ Do not recall** Date: \_\_\_\_\_  
 Do you have the same/similar condition? **Yes/ No/ Do not recall**  
 If yes, explain: \_\_\_\_\_
  
3. Explain any previous hospitalizations: \_\_\_\_\_  
 Do not recall any previous hospitalizations
  
4. Have you had any previous work-related injuries? **Yes/ No/ Do not recall** Date: \_\_\_\_\_  
 Do you have the same/similar condition? **Yes/ No/ Do not recall**  
 Explain any changes in intensity/frequency/duration of the pain you feel currently: \_\_\_\_\_
  


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5. List any medications you are currently taking and explain any side-effects:  Not applicable  
 Insulin       Cortisone       Nerve Pills       Antidepressants       Shoe lifts  
 Blood pressure medication                       Vitamins/supplements  
 Aspirin--How often? \_\_\_\_\_       Pain killer/muscle relaxants  
 List any known side effects: \_\_\_\_\_

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Claim Number:** \_\_\_\_\_

6. Please list any allergies:  none known  dairy products  eggs  mold  peanuts  
 perfume  pet dander  poison ivy  pollen  smoke  strawberries  
 wheat  other—Please explain: \_\_\_\_\_

7. Have you had any surgeries? **Yes/ No/ Do not recall**  
 What type(s) and date(s)? \_\_\_\_\_

8. Please check all that apply.  use alcohol  use tobacco  use caffeine  use alternative medicine  
 exercise regularly  have good sleep habits  have a well-balanced diet  
 eat low salt/fat diet  experiencing stress at home/work

Include any explanation you feel necessary: \_\_\_\_\_

**CHIEF COMPLAINT** (all clients fill out)

Note: Ranking 1-10 key: 1-4=mild, uncomfortable; 5-7= distressing; 8-10= intense, unbearable

A. Check all that apply. Do you experience:

- Neck pain-** Where:  shoots into upper back on right side  shoots into upper back on left side  
 upper/lower  more right sided  more left sided  other: \_\_\_\_\_

Intensity: (rank 1-10): \_\_\_\_\_ Comments: \_\_\_\_\_

- Headaches-** Where:  whole head  forehead  back of head  behind eye  temple  right side  
 left side  other: \_\_\_\_\_

Intensity: (rank 1-10): \_\_\_\_\_ Comments: \_\_\_\_\_

- Mid back pain-** Where:  whole mid back  more right sided  more left sided  
 shooting around chest  other: \_\_\_\_\_

Intensity: (rank 1-10): \_\_\_\_\_ Comments: \_\_\_\_\_

- Low back pain-** Where:  whole low back  more right sided  more left sided  
 shoots into right/left leg  other: \_\_\_\_\_

Intensity: (rank 1-10): \_\_\_\_\_ Comments: \_\_\_\_\_

- Other:** \_\_\_\_\_ - Where specifically: \_\_\_\_\_

Intensity: (rank 1-10): \_\_\_\_\_ Comments: \_\_\_\_\_

B. Do you have bowl or bladder problems: **Yes/ No**

- C. Do you feel pain in the:  right arm  left arm  right leg  left leg  ankles  knee  hips  
 not applicable

- D. Do you feel:  numbness or tingling in the legs and/or feet  loss of balance  
 numbness or tingling in the arms  not applicable

E. Describe any additional information regarding your condition:

\_\_\_\_\_

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Claim Number:** \_\_\_\_\_

- F. Possible jaw pain symptoms. Check all that apply:
- ear pain, ache, itch, sharp pain
  - ringing in the ear
  - dizziness
  - teeth problems
  - face numbness
  - grind teeth at night
  - jaw joint pain or clicking
  - ear fullness, plugged
  - other experienced TMJ related symptoms not listed: \_\_\_\_\_
  - not applicable

- G. Possible foot/leg related symptoms. Check all that apply:
- deep knee pain
  - knee pain
  - foot pain
  - foot numbness at bottom of foot
  - hip pain
  - low back pain
  - pelvic pain
  - whole leg pain
  - other experienced TMJ related symptoms not listed: \_\_\_\_\_
  - not applicable

- H. Possible brain and brainstem related symptoms. Check all that apply:
- problems w/ long or short term memory
  - concentration problems
  - aggravation by noise
  - anxiety
  - depression
  - irritability
  - sleep problems
  - sex problems
  - fatigue
  - change in smell or taste
  - other--please explain: \_\_\_\_\_
  - not applicable

- I. How long/regularly do you experience the pain?
- all the time
  - during the day
  - during the night
  - more than 6 hours
  - less than 1 hour
  - in intervals--How long each time? \_\_\_\_\_
  - other--Please explain: \_\_\_\_\_

- J. What makes the symptoms better?
- aspirin
  - movement—In what direction: \_\_\_\_\_
  - heat
  - ice
  - massage
  - muscle relaxants
  - rest
  - stretching
  - bed rest
  - elevation
  - nothing
  - other--Please explain: \_\_\_\_\_

K. Describe any activities that make symptoms worse:  
\_\_\_\_\_

L. How and when did the pain begin: \_\_\_\_\_

M. Did the accident/injury/incidence of pain occur more than two weeks ago? **Yes/No**  
If yes, please explain why you did not come in before two weeks: \_\_\_\_\_  
\_\_\_\_\_

**PHYSICAL EXAMINATION** (Dr. Noble or Assistant complete)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B.P. \_\_\_\_/\_\_\_\_ Pulse: \_\_\_\_\_

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Claim Number:** \_\_\_\_\_

**CONSENT TO TREAT & FINANCIAL AGREEMENT (Please read and sign)**

I hereby authorize the Doctor to treat my condition/the condition of my child or legal ward (*please circle*) as he deems appropriate.

The primary treatment used by the Doctor is spinal manipulative therapy; this will be used for treatment. Hands or a mechanical instrument may be used upon my body in such a way as to move my joints. That may cause an audible "pop" or "click," and I may feel a sense of movement. Other treatment options include: self-administered, over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers, hospitalization, and surgery. If one of these "other treatment" options is chosen, I am aware that there are risks and benefits of such options and that I may want to discuss these with my primary care physician.

I fully understand that I am directly and fully responsible to the Clinic for all bills incurred for services rendered to me and that this agreement is made solely for the Clinic's additional protection and in consideration contingent on any settlement, judgment or verdict by which I may eventually recover. I am personally responsible for my bills, regardless of the outcome of any legal claim or cause.

I authorize my insurance company to issue payment directly to this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions.

**We will call to verify eligibility and benefits as a courtesy to our patients. As the insurance policy is a contract between the patient and the insurance company we cannot guarantee these benefits. Any amount that the insurance company does not cover becomes the responsibility of the patient, regardless of any reduction, denials or arbitrary determination of usual and customary fees. We advise our patients to verify their own insurance.**

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Noble and have had my questions answered to my satisfaction. By signing below I state I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

I have also read, understand, and agree to the financial agreement stated above.

\_\_\_\_\_  
Date Patient Signature, or Parent/Legal Guardian for patient under 18 years

\_\_\_\_\_  
Date Witness' Signature

**OUR CANCELATION POLICY & OFFICE NOTICE**

An appointment is a commitment by yourself and the doctor to set aside time to treat you. Therefore, we request that our patients notify us at least 24 hours in advance when canceling or rescheduling an appointment so that we may make the appointment available to those who need it.

We reserve the right to charge a Missed Appointment Fee of \$25.00 to those patients who miss their appointment without notifying us, or who cancel/ reschedule an appointment with less than 24-hour notice. This fee is not covered by insurance and will need to be paid by the patient.

So as not to inconvenience those who arrive at their appointed time, late comers may receive shortened treatment at the regular treatment fee. Those who arrive for their scheduled appointments will be served first.

Also, we are not responsible for lost or stolen personal items. We are not responsible for your children or any children that might be with you during your visit. We are not responsible for any injuries that occur at home from doing exercises the doctor gives you.

We value your business and strive to ensure that we are always available to you when you need us. Thank you.

I understand and agree to the above:

\_\_\_\_\_  
Patient Signature Date

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_ (your name), acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Enterprise Chiropractic, which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Print Name

**For Office Use Only**

The Practice has made a good-faith effort to obtain an acknowledgement of \_\_\_\_\_'s receipt of our Notice of Privacy Practices. In an effort to obtain it, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner:  Personally  Mail  Phone Follow-up  Other \_\_\_\_\_

In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons:  Patient unavailable  Patient physically unable  Patient unwilling. Signature/Date \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Claim Number: \_\_\_\_\_

**MOTOR VEHICLE ACCIDENT INFORMATION** (MVA clients only)

1. Date of accident: \_\_\_\_\_: Number of cars involved in accident: \_\_\_\_\_
  
2. Auto you were in: Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_  
Damage:  minor  major  totaled  approx. \$ \_\_\_\_\_ worth  
Where you the owner of the car: Yes/ No
  
3. Other auto(s): Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_  
Damage:  minor  major  totaled  approx. \$ \_\_\_\_\_ worth  
Area damaged:  front  rear  driver side  passenger side
  
4. Street/Intersection Name(s): \_\_\_\_\_  
City/State: \_\_\_\_\_
  
5. Was it:  intersection  light/stop sign (circle one)  not intersection  
If at a light, was it:  green  yellow  turn arrow  
Street surface:  dry  wet  slick  icy  gravel  Other: \_\_\_\_\_
  
6. How fast and in what direction was the *other* car moving when you hit?  
\_\_\_\_\_
  
7. How fast and in what direction was your car moving when it hit?  
\_\_\_\_\_
  
8. Where were you sitting in the vehicle?  
 driver  front passenger  passenger in the back left/right/center (please circle)  
 riding in truck bed  motorcycle driver/passenger (please circle)  
 other--Please specify: \_\_\_\_\_
  
9. How was your body positioned at the time of the accident?  
 looking downward doing something else  looking at the accident coming  
 looking at passenger  looking straight ahead  
 turned to the left/right (please circle)  looking at oncoming traffic  
 looking in the rear view mirror  looking at the driver  
 other--Please specify: \_\_\_\_\_
  
10. What area(s) on your car were hit?  
 front passenger corner  front driver side corner  front bumper  
 passenger side  driver side  rear passenger corner  
 rear driver side corner  rear bumper  rear trailer  
 totaled  head on collision  Other: \_\_\_\_\_
  
11. My body hit the  steering wheel  side panel  head rest  
 seat with my chest/abdomen/head/face  upper back (please circle)  
 door  dashboard  back of driver's seat  pavement  
 console  other--Please explain: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Claim Number: \_\_\_\_\_

12. The following parts of my body hit:  face  chest  arm  shoulder  
 hip  abdomen  wrist  hand  fingers  nose  forehead  neck  shin  
 thigh  knee  other--Please explain: \_\_\_\_\_

13. Additional accident description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Where you able to brace for impact: **Yes/ No**

15. Was there a warning before impact? **Yes/ No**

16. Did the airbag deploy? **Yes/ No**

17. Does your car have a headrest? **Yes/ No**

18. As a result of the accident were you:  shaken but could function  
 unable to move certain body parts--Please explain what parts and why: \_\_\_\_\_  
 bruised or bleeding (please describe injuries) \_\_\_\_\_  
 rendered unconscious  able to get up/out of car and walk unaided  
 dazed  vague about what happened.

19. Do you recall hitting your head?  Do not recall if I did or did not hit my head  
 Yes, I recall hitting my head  No, I did not hit my head

**Following the accident:**

20. Was emergency staff at the scene? **Yes/No**

21. Were you taken to a hospital emergency room? **Yes/No**  
If yes, hospital name: \_\_\_\_\_ What areas were check/treated? \_\_\_\_\_

22. Did you make follow-up treatments for the injuries? **Yes/No**  
If yes, what hospital? \_\_\_\_\_

23. Were X-rays taken? **Yes/No** If yes, what body parts? \_\_\_\_\_  
By whom? \_\_\_\_\_

24. Did you suffer from any conditions other than the symptoms already listed that arose after the accident? **Y/N**  
If yes, please explain: \_\_\_\_\_

25. Have you reported the accident to your insurance company? **Yes No**

26. Have you retained an attorney to represent you for this accident? **Yes No**  
If yes, please provide the following for our records:  
Attorney's Name: \_\_\_\_\_ Phone # \_\_\_\_\_  
Attorney's Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Claim Number: \_\_\_\_\_

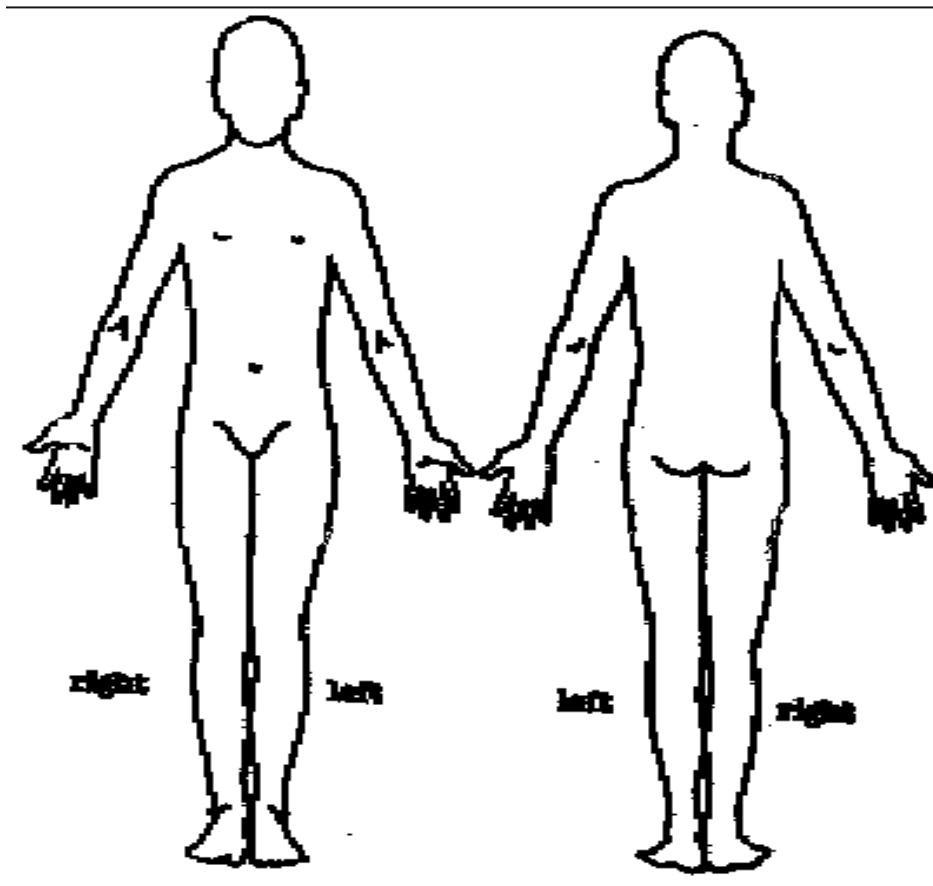
**SHOW AREA(S) OF PAIN OR UNUSUAL FEELING**

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	0000000	X X X X X X	* * * * *	///////
-----	0000000	X X X X X X	* * * * *	///////
-----	0000000	X X X X X X	* * * * *	///////

Please mark the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

**Pain Chart**



**Neck-Shoulder-Arm Pain**

On a scale of zero to 10, I rate my Discomfort as follows  
 ( \_\_\_\_\_ )  
 0 10  
 No pain Severe pain

**Mid Back Pain**

On a scale of zero to 10, I rate my Discomfort as follows  
 ( \_\_\_\_\_ )  
 0 10  
 No pain Severe pain

**Low Back and Leg Pain**

On a scale of zero to 10, I rate my Discomfort as follows  
 ( \_\_\_\_\_ )  
 0 10  
 No pain Severe pain

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

## SYSTEMS REVIEW

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

FILE #: \_\_\_\_\_

Please review the following list of conditions. If you have had a condition in the *Past*, check column 1. If you have a condition *Now*, check Column 2.

Past	Now	GENERAL	Past	Now	GASTRO-INTESTINAL
		784 Headaches			783 Poor Appetite
		780.6 Fever			536.8 Poor Digestion
		780.9 Chills			994.2 Excessive Hungary
		780.8 Night Sweats			787.3 Belching or Gas
		780.2 Fainting			787 Nausea
		780.4 Dizziness			787 Vomiting
		780.3 Convulsions			578 Vomiting Blood
		780.52 Loss of Sleep			536.8 Pain over stomach
		780.7 Fatigue			564 Constipation
		799.2 Nervousness			558.9 Diarrhea
		783 Weight Loss			789 Colon Trebles
		782 Pain/Numb Limbs			455.6 Hemorrhoids/Piles
		995.3 allergy			785.1 Liver Trouble
		786.09 Wheezing			782.4 Jaundice
		729.2 Neuralgia			575.98 Gall Bladder Trouble
Past	Now	EYE, EAR, NOSE, THROAT	Past	Now	FOR WOMEN ONLY
		368.9 Poor Vision			786.2 Painful Periods
		378.9 Crossed eyes			626.2 Excessive Flow
		379.91 Pain in eyes			626.4 Irregular Cycles
		689.9 Deafness			627.2 Hot Flashes
		388.7 Earache			625.3 Cramps/Backache
		388.3 Ear Noises			634.6 Miscarriage
		388.6 Ear Discharges			623.5 Vaginal Discharge
		478.1 Nasal Obstruction			Pregnancy
		784.7 Nose Bleeds			
		462 Sore Throat			
		784.49 Hoarseness			
		477.9 Hay Fever			
		793.9 Asthma			
		460 Frequent Colds			
		240.9 Enlarged Thyroid			
		463 Tonsillitis			
		686.9 Sinus Troubles			
Past	Now	CARDIO-VASCULAR	Past	Now	MUSCLE & JOINTS
		783 Rapid Heart			Weakness
		427.89 Slow Heart			Twitching
		401.9 High Blood Pressure			847 Stiff Neck
		458.9 Low Blood Pressure			722.1 Backache
		786.51 Pain over Heart			719 Swollen Joints
		438 Heart Trouble			781 Tremors
		719.07 Ankle Swelling			729.5 Foot Troubles
		459.9 Poor Circulation			724.79 Painful Tail Bone
		Varicose Veins			724.5 Pain between shoulders
		436 Strokes			553.9 Hernia
Past	Now	GENITAL-URNIARY	Past	Now	SKIN OR ALLERGIES
		788.3 Frequent Urination			368.9 Skin Eruptions
		788.1 Pain during Urination			698.9 Itching
		599.7 Blood in Urine			287.8 Bruise Easily
		592 Kidney Infection			701.1 Dryness
		788.3 Bed Wetting			Boils
		788.1 Can't Control Urination			782 Sensitive Skin
		601.9 Prostate Trouble			708.9 Hives/Allergy
					692.9 Eczema
					Medicines

Last Pap Date: \_\_\_\_\_  
 Start Date of last Period: \_\_\_\_\_

## SYSTEMS REVIEW

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ FILE #: \_\_\_\_\_

Please review the following list of conditions. If you have had a condition in the Past, check column 1. If you have a condition Now, check Column 2.

Past	Now	NA	HABITS	Past	Now	RESPIRATORY			
			Smoking _____ packs/day			786.2 Chronic Cough			
			Alcohol _____ drinks/day			766.3 Spitting Blood			
			Coffee _____ cups/day			933.1 Spitting Phlegm			
			No Exercise			786.5 Chest Pain			
			Moderate Exercise			786.09 Difficulty Breathing			
			Daily Exercise						
FAMILY HISTORY				Diabetes	Heart	Kidney	Cancer	Back	NONE
Mother	0	Living	0 Deceased						
Father	0	Living	0 Deceased						
Brothers			How Many? _____						
Sisters			How Many? _____						

CHECK ANY DISEASE YOU HAVE HAD:						
		541	Appendicitis			285.9 Anemia
		541	Pneumonia			285.9 Measles
		541	Rheumatic Fever			285.9 Mumps
		541	Polio			285.9 Chicken Pox
		541	Tuberculosis			285.9 Diabetes
		541	Whooping Cough			285.9 Cancer
		429.9	Heart Disease			716.9 Arthritis
		429.9	Goiter			716.9 Epilepsy
		429.9	Influenza			716.9 Mental Disorder
		429.9	Pleurisy			716.9 Lumbago
		429.9	Alcoholism			716.9 Eczema
		429.9	Venereal Disease			

LIST ANY ALLERGIES YOU HAVE:



**IRREVOCABLE DOCTOR’S LEIN  
AND ASSIGNMENT OF RIGHT TO RECOVERY**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Claim Number:** \_\_\_\_\_

In consideration and exchange for not having to immediately pay a debt owed and in consideration for receiving future care at or by the clinic and doctor on whose letterhead this document is printed (hereinafter “Clinic”), I, the undersigned, hereby assign and convey to the Clinic a legal and equitable interest in any and all causes of action or rights of recovery I may have arising out of that certain accident or injury-producing event which occurred on or about \_\_\_\_\_, to the full extent of the cost and treatment provided or to be provided me by the Clinic.

I hereby authorize and direct my attorney(s) to hold in trust, and to pay directly the Clinic such sums as may be due and owing the Clinic for treatment and other professional services rendered me both by reason of this accident and by reason of any other bills that are due the Clinic and to withhold such sums from any given, grant and convey a lien on my case to the Clinic against any and all proceeds of any and all causes of action, settlements, judgments or verdicts which may be paid to or through my attorney, or myself, as the result of injuries or conditions for which I have been treated by the Clinic.

If no attorney is trusted with my case, I understand that the insurance will directly pay the Clinic for all services rendered as a result of this accident and any other bills that are due.

I fully understand that I am directly and fully responsible to the Clinic for all bills incurred for services rendered me and that this agreement is made solely for the Clinic’s additional protection and in consideration contingent on any settlement, judgment or verdict by which I may eventually recover. I am personally responsible for my bills, regardless of the outcome of any legal claim or cause.

I fully understand that if my attorney(s) does/do not protect the Clinic’s interest, the Clinic may require me to make payments on a current basis. The Clinic may also bring a cause of action against my attorney(s) for failing to honor this binding and irrevocable agreement between me and the Clinic.

I further understand and agree that the Clinic *is not* responsible for paying any of my attorneys’ fees and the Clinic *does not* agree to pay my attorney fees for honoring this agreement between me and the Clinic.

**“I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY(S) TO PROTECT THE CLINIC’S AND DOCTOR’S INTEREST AT TIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHTS TO THE CLINIC. I ALSO KNOW I MAY NOT REVOKE THIS AGREEMENT AT ANY TIME WITHOUT PRIOR WRITTEN AUTHORIZATION FROM THE CLINIC. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT AND LEIN.**

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**AUTHORIZATION TO DISCLOSE MEDICAL RECORDS**

Oregon Revised Statute 192.525, 1997

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Claim Number:** \_\_\_\_\_

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize \_\_\_\_\_ (name of hospital/health care provider) to release a copy of the medical information for \_\_\_\_\_ (name of patient) to Enterprise Chiropractic Clinic, 9900 SW Greenburg Rd. Suite 225, Tigard, OR 97233(name and address of recipient).

The information will be used on my behalf for the following purpose(s):  
\_\_\_\_\_  
\_\_\_\_\_

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

- \_\_\_ All hospital records (including nursing records and progress notes)
- \_\_\_ Transcribed hospital reports
- \_\_\_ Medical records needed for continuity of care
- \_\_\_ Most recent five year history
- \_\_\_ Laboratory reports
- \_\_\_ Pathology reports
- \_\_\_ Diagnostic imaging reports
- \_\_\_ Clinician office chart notes
- \_\_\_ Dental records
- \_\_\_ Physical therapy records
- \_\_\_ Emergency and Urgency care records
- \_\_\_ Billing statements
- \_\_\_ Other

**\_\_\_ Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.**

- \_\_\_ \*HIV/AIDS-related records
- \_\_\_ \*Mental Health information
- \_\_\_ \*Genetic testing information \_\_\_\_\_ \*Must be initialed to be included in other documents.
- \_\_\_ \*\*Drug/alcohol diagnosis, treatment or referral information: \*\*Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.

\_\_\_ This authorization is limited to the following treatment:  
\_\_\_\_\_

\_\_\_ This authorization is limited to the following time period:  
\_\_\_\_\_

\_\_\_ This authorization is limited to a worker's compensation claim for injuries of \_\_\_\_\_(date)/

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ (Date)	_____ (Signature of Patient)
_____ (Date)	_____ (Signature of person authorized by law)

**ENTERPRISE CHIROPRACTIC**  
**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 practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of Our Privacy Practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of 04/15/03, and will remain in effect until we replace it.

**CHANGES TO NOTICE:**

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:**

**A. TREATMENT, PAYMENT, and HEALTH CARE OPERATIONS:** You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and health care operations. Examples of these activities are as follows:

- **Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare Operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

**B. AUTHORIZATIONS:** You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Claim Number:** \_\_\_\_\_

**C. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

**D. MARKETING:** We will not use your health information for marketing communications without your written authorization.

**E. USES OR DISCLOSURES REQUIRED BY LAW:** We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are the possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

**F. PATIENT AND THIRD PARTY PROTECTION:** Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**G. LAW ENFORCEMENT / NATIONAL SECURITY:** Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities.

**H. APPOINTMENT REMINDERS:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

### **PATIENT RIGHTS:**

**A. ACCESS TO RECORDS:** Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we will charge you \$0.25 for each page and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Claim Number: \_\_\_\_\_

B. ACCOUNTING OF CERTAIN DISCLOSURES: Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before **April 14, 2003**. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

D. AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. ELECTRONIC NOTICES: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form as well.

#### **QUESTIONS AND COMPLAINTS:**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decision we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

**CONTACT:** Dr. Albert Noble, Enterprise Chiropractic Clinic  
**FAX:** 503-639-2052  
**E-MAIL:** [info@drnoble.net](mailto:info@drnoble.net)