1761 Jeffco Boulevard
Arnold, MO 63010

BRADLEY CHIROPRACTIC

PATIENT INFORMATION:

Today's Date: _____ Patient's Full Name: _____

Street Address: _____

City, State, Zip: _____

Home Number: _____ Cell Number: _____

Birth Date: _____ Sex: M _____ F _____ Age: _____

SSN: _____ Single: ___ Married: ___ Widowed: ___ Divorced: ___

Preferred language: _____ Race: _____ Ethnicity: _____

Occupation: _____ Employer Name: _____

Employer Address: _____

Employer Phone Number: _____

Emergency Contact: _____ Emergency Phone Number: _____

Email Address: _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION:

Who is responsible for account? _____

Relationship to patient: _____ Birth Date: _____ SSN: _____

Insurance Co: _____ Insurance ID #: _____ Group #: _____

Provider/Customer Service Phone Number (from the back of your insurance card): _____

Is patient covered by a 2nd insurance? Y ____ N ____

If yes, Cardholder's Name: _____ Relationship to patient: _____

Insurance Co: _____ Insurance ID #: _____ Group #: _____

PATIENT CONDITION:

Reason for visit: _____ When did symptoms appear? _____
Is this condition getting worse? Y _____ N _____ How often do you have this pain? _____
Is it constant or come and go? _____
Does it interfere with: Work __ Sleep __ Other __
Activities or movements painful to perform: Sitting __ Walking __ Standing __ Bending __

PATIENT HEALTH HISTORY

Have you ever seen a chiropractor before? Yes ___ No ___

What treatment have you already received for your condition?
Medication ___ Surgery ___ Physical Therapy ___ Chiropractic Services ___ None ___
Other _____

Name of doctor(s) who have treated you for your condition:
_____

SYSTEM REVIEW

Please place a checkmark to the left of each condition you currently have or have had in the past:

	Headaches		Chest Pains		High Blood Pressure
	Neck Pain		Stroke		Heart Attack
	Upper Back Pain		Angina		Lupus
	Mid Back Pain		Kidney Stones		Epilepsy
	Lower Back Pain		Kidney Disorders		HIV/AIDS
	Shoulder Pain		Bladder Infection		Hormonal Replacement
	Elbow/Upper Arm Pain		Painful Urination		Dermatitis/Eczema/Rash
	Wrist Pain		Loss of Bladder Control		Allergies
	Hand Pain		Prostate Problems		Smoking/Tobacco Use
	Hip Pain		Abnormal Weight Loss/Gain		Drug/Alcohol Dependence
	Upper Leg Pain		Loss of Appetite		Birth Control Pills
	Knee Pain		Abdominal Pain		Cancer
	Ankle/Foot Pain		Ulcer		Tumor
	Jaw Pain		Hepatitis		Excessive Thirst
	Joint Pain/Stiffness		Muscular Incoordination		Frequent Urination
	Arthritis		Dizziness		Depression
	Rheumatoid Arthritis		Diabetes		Asthma
	Liver/Gall Bladder Disorder		General Fatigue		Chronic Sinusitis
	Visual Disturbances				

If there's anything we didn't cover here that you think our doctors should know, please tell your assistant and/or list below:

_____

_____

_____

Female Patients:

I hereby certify that to the best of my knowledge, I am not pregnant and Bradley Chiropractic has my permission to take x-rays of me. _____ **Initial Here**

Date of last menstrual cycle: _____

Do you have implants of any kind? Yes ___ No ___

What are your current smoking habits?

Smoke every day___ Smoke some days___ Former smoker___ Never smoked____

FAMILY HISTORY:

	Diabetes	Heart	Kidney	Cancer	Back	Other
Mother – Living □ Y □ N	□	□	□	□	□	_____
Father – Living □ Y □ N	□	□	□	□	□	_____
Brother(s), # of _____	□	□	□	□	□	_____
Sister(s), # of _____	□	□	□	□	□	_____
Grandmother(s)	□	□	□	□	□	_____
Grandfather(s)	□	□	□	□	□	_____
Adoption History	□	□	□	□	□	_____

ALLERGIES:

_____ _____ _____ _____

INJURIES/SURGERIES:

Description: _____ **Date**:_____

Accidents/Falls _____

_____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

_____

MEDICATIONS: (if additional space is needed, please write on reverse side)

Name:	**Dosage**:	**Taken for**:
_____	_____ mg _____ times a day	_____
_____	_____ mg _____ times a day	_____
_____	_____ mg _____ times a day	_____
_____	_____ mg _____ times a day	_____
_____	_____ mg _____ times a day	_____
_____	_____ mg _____ times a day	_____
_____	_____ mg _____ times a day	_____
_____	_____ mg _____ times a day	_____

VITAMINS and/or SUPPLEMENTS:

Name:	**Dosage**:	**Taken for**:
_____	_____ mg _____ times a day	_____
_____	_____ mg _____ times a day	_____
_____	_____ mg _____ times a day	_____

FINANCIAL POLICY:

1. It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services, including those not reimbursed by third party payers.
2. Returned checks and balances over 30 days will be subjected to interest at the maximum legal rate from that date until paid in full. Past due accounts will be sent to collections after 90 days. In the event that it becomes necessary to turn the account over to a collection agency, the patient will be responsible for all costs involved.
3. A fee of $10.00 will be charged to patients who miss their appointment without notifying the office one hour prior to their scheduled appointment time.
4. Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for our mutual benefit.

I have read, understand & agree to the office and financial policies for Bradley Chiropractic.

Signed: _____ Date: _____

Staff Signature: _____ Date: _____

INSURANCE POLICY:

As a courtesy, Bradley Chiropractic verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claims will process according to your plan. If your claim processes differently from the benefits quote, the insurance company will side with the plan and not honor the quoted benefits. We require all patients to pay their deductible, copay and/or co-insurance amounts at time of service, unless other payment arrangements have been made. It is also the patient's responsibility to notify our staff of any changes in insurance carriers and/or policies that may incur throughout the year. We are contracted with most insurance carriers and are happy to file any and all necessary paperwork to your insurance carrier. Understand that you are fully responsible for all charges incurred.

_____ **Initial Here**

HIPAA Notice of Privacy Practices

BRADLEY CHIROPRACTIC, LLC
1761 Jeffco Blvd Arnold, MO 63010
636-296-1222

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

_____ _____

Patient Signature Date