EPC
ELITE PERFORMANCE
CHIROPRACTIC

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here: Dr._____ and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr._____ and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:	To be completed by the patient's representative, if necessary, (eg: if the patient is a minor or is physically or mentally incapacitated)
_____	_____
Print Patient's Name	Print Name of Patient
	_____
	Print Name of Representative
_____	_____
Signature of Patient	Signature of Representative

This form should be maintained in the patient's health record.

2002 New Garden Road, #205, Greensboro, NC 27410
336-617-8113 – office / 336-617-8190 - fax

Notice of Privacy Practices Acknowledgment/Phone Message & Contact Authorization

Patient Name: _____ Date of Birth: _____
(Last) (First) (MI)

THIS FORM IS VALID FOR 1 YEAR:

By signing this form you are giving Elire Performance Chiropracric (EPC) permission to use and disclose your personal health information (PHI). The Notice of Privacy Practice (NPP) tells you how EPC may use and share your PHI. It also describes your rights with respect to your health records.

- ✓ We will use and share your health records to treat you and to bill you for the services we provide.
- ✓ We will use and share your health records for business operations.
- ✓ We will use and share your health records as required/allowed by law.

EPC reserves the right to change the privacy practices as stated in the NPP. I understand the most recent NPP is available on the EPC website (elireperformancechiropracric.com) and is prominently posted in my physician's office. I may request a copy at any time.

I acknowledge receipt of the EPC Notice of Privacy Practices (NPP). I have been given time to review the NPP and I have been encouraged to read it and ask any questions that I may have prior to signing this consent.

I have the right to request that EPC restrict how my PHI is used or disclosed.
EPC is not required to agree to your requested restriction, but if EPC does agree to the restriction, we will honor the restriction.

I have the right to revoke this consent except to the extent that EPC has already taken action covered under the consent. If I choose to revoke this consent, I must do so in writing.

Signature of Patient: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Name of Authorized Representative: _____ Date: _____

Phone Message and Contact Authorization

Who does EPC have your permission to leave messages with containing your medical and/or financial information? Please CHECK the appropriate answer below:

☐ **Self ONLY**

May we leave a message? ☐ No ☐ Yes

☐ **Self & those noted below**

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Signature of Patient: _____ Date: _____
Signature of Authorized Representative: _____ Date: _____
Name of Authorized Representative: _____

OFFICIAL USE ONLY
MR #: **ID VERIFIED:**

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

Elite Performance Chiropractic
2002 New Garden Road, Suite 205
Greensboro, NC 27410
(336) 617-8113

NOTICE OF PRIVACY PRACTICES

1. Elite Performance Chiropractic may use and disclose protected health information for treatment, payment, and healthcare operations. Examples of these include, but are not limited to, requested preschool, or sports physicals, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.
2. Elite Performance Chiropractic is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.
3. Elite Performance Chiropractic will not use or disclose PHI for marketing purposes and/or disclosures constituting a sale of PHI without the individual's authorization.
4. Elite Performance Chiropractic will not sell or make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
5. Elite Performance Chiropractic will abide by the terms of this notice currently in effect at the time of the disclosure.
6. Elite Performance Chiropractic reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Elite Performance Chiropractic will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
7. Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes.
8. Any patient, guardian or personal representative has the right to inspect and obtain copies of their medical record. The records will be provided within 30 days of the request, and a reasonable charge may be assessed for any copies after the first request in a 12-month period. If Elite Performance Chiropractic is unable to act within the required period, Elite Performance Chiropractic, may provide the patient with written notice of the reason for delay and expected date of completion of the request. This extension of time will not exceed 30 days.
9. Any patient, guardian or personal representative has the right to request amendments be made to their medical record.
10. Any patient, guardian or personal representative has the right to request a 6-year accounting of all disclosures of their medical record. The history will be provided within 30 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12-month period. If Elite Performance Chiropractic is unable to act within the required period, Elite Performance Chiropractic may provide the patient/person with written notice of the reason for delay and expected date of completion of the request. This extension of time will not exceed 30 days.
11. Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. Elite Performance Chiropractic is not required to agree to the restrictions requested, but if Elite Performance Chiropractic does agree, Elite Performance Chiropractic must abide by those restrictions.
12. Any patient, guardian or personal representative has the right to restrict disclosure of certain Personal Health Information to a health plan for payment or health care operation purposes, but not for treatment purposes, for items or services that have been paid in full and out-of-pocket.
13. Any person/patient has the right to be notified by the Elite Performance Chiropractic Privacy Officer following a breach of unsecured Personal Health Information of the affected individual. Elite Performance Chiropractic may use email to notify the person/patient of a breach.
14. Any person/patient may file a complaint to Elite Performance Chiropractic and to the U.S. Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Elite Performance Chiropractic, please contact the Privacy Officer at the following address and/or phone number, Elite Performance Chiropractic, 2005 New Garden Road, Suite 205, Greensboro, North Carolina 27410, telephone (336) 617-8113. All complaints will be addressed and the results will be reported to the Privacy Officer.
15. It is the policy of Elite Performance Chiropractic that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

Effective Date:_____

Name of Patient:_____

Signature of Patient or Legal Guardian:_____

Date:_____

EPC
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CHIROPRACTIC

Patient History Form

Name _____ Age _____ Date _____
Address_____ City_____ State _____ Zip _____
Home phone _____ Work# _____ Cell# _____
Date of Birth _____ Soc Sec# _____ Sex: M F Marital Status: S M D W
Height _____ Weight _____
Employer _____ Occupation _____
Email (optional) _____
Referred by anyone? _____
If Insured under another person: Name _____ Relation: _____
Insured's Date of Birth: _____ __ Employer _____
In case of an Emergency: Name _____ Relation _____ # _____

Present condition due to an injury/accident? Yes_____ No_____ / On the Job_____ Auto Accident_____
Other_____
Has the accident been reported? Yes___ No___ To Employer___ Auto Insurance___ Other_____

Health Report

Reason for seeking care _____
List any other Doctors seen for this condition _____
List any diagnosis and type of treatment _____
Have you had similar injuries or accidents before? Yes___ No___ If Yes, please explain:_____
List names of relatives that have or have had a similar problem: _____
Have you received chiropractic treatment before?_____ If yes, explain:_____
Any recent X-Rays / MRI?_____
Have you been treated by a physician for any health conditions within the last year? Yes___ No___
If yes, please explain: _____
Please list any medications you are currently taking: _____
List conditions you are taking medications for: _____
Do you take Vitamins/Supplements? Yes___ No___ / What kind/s and how often? _____
Do you smoke? Yes___ No___ / Caffeinated Drinks per day_____
Drink Alcohol? Yes___ No___ / Daily____ Weekly____ Social Occasions_____

Family Health History

List any Health conditions / age of death and cause of death if deceased:
Father: _____
Mother: _____
Brother/s & Sister/s: _____

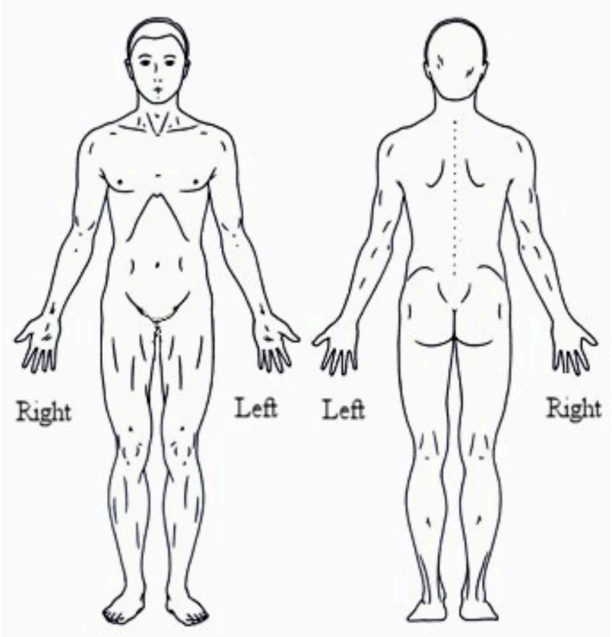
Please circle degree of pain. 0 none. 10 severe pain

0 1 2 3 4 5 6 7 8 9 10

Mark on the diagram to the right, where you feel pain

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	///////
Other	^^^^

What activities aggravate your pain?
_____
What activities lessen your condition/pain?
_____
Is this condition worse at certain times of the day? Y N
Is it interferring with: Work?_____ Sleep? _____
Routine? _____ Other? _____
Is this condition progressivley getting worse?
_____



Please mark each item below for each sign or symptom you presently have or previously had:

P = past C = current

GENERAL SYMPTOMS:
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS:
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains / Strains
__ Broken Bones

CARDIO-VASCULAR:
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/ NOSE/ THROAT:
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL:
__ Belching / Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver / Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss / Gain

RESPIRATORY:
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY:
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control
__ Kidney Stones

SKIN OR ALLERGIES:
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema / Rash / Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY:
__ Birth Control _____
__ Hormone Replacement
__ Cramps / Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this time? Y N

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient Signature:_____ Date:_____