Patient Name:_____ Patient Date of Birth:_____

PATIENT

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DEMOGRAPHIC FORM

PATIENT INFORMATION

Patient Name: _____ Date **of Birth:** _____

Social Security #_____/_____/_____ **Sex**: □ M □ F **Marital Status:** □ Single □ Married □ Widower □ Divorced

Race: □ African American □ Caucasian **Ethnicity:** □ Latin/ Hispanic/ Spanish □ Non-Latin/Hispanic/Spanish □ Asian

Language: □English □Spanish □Other:_____

Address _____**Apt**_____**City**_____ **State**_____ **Zip code**_____

Home Phone_____ **Cell Phone** _____**Work Phone** _____

Email Address_____

How were you referred to our office? _____

Primary Care Physician: _____

GUARANTOR/PARENT/ RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____**DOB**_____/_____/_____ **Social Security No:** _____/_____/_____

Address _____**Home Phone**_____

Employer_____**Work Phone**_____

Relationship to Patient_____ **Cell Phone**_____

IS THIS INJURY WORK RELATED? Yes / No
(If yes, please fill out the following)
Workers' Comp Name: _____ Adjuster's Name: _____

Phone: _____ Case #: _____ Date of Injury: _____/_____/_____
Are you Currently Working: No / Part Time with Restrictions / Full Time Regular Duties

Preferred Pharmacy: _____

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Age: _____ **Height:** _____ **Weight:** _____

1) **What is your MAIN reason for your visit today?** _____

_____

_____

Neck	**Shoulder**	**Elbow**	**Pelvis**	**Knee**	**Ankle**	**Foot**
Radiates ___R Arm	___Right	___Right	___Right	___Right	___Right	___Right
Radiates ___L Arm	___Left	___Left	___Left	___Left	___Left	___Left

Back	**Arm**	**Wrist**	**Hip**	**Hand**	**Fingers**	**Toes**
Radiates ___R Leg	___Right	___Right	___Right	___Right	___Right	___Right
Radiates ___L Leg	___Left	___Left	___Left	___Left	___Left	___Left

2) **How long has the problem been present?**

_____

3) **Did an injury event take place?** □Work Injury □Motor Vehicle Accident □Fall □Sports Injury □Other:_____ □Cannot Identify

4) **Severity of Pain?** 0 1 2 (mild) 3 4 5 (moderate) 6 7 8 (severe) 9 10 (extremely severe)

5) **Quality of Pain?** □Aching □Burning □Gnawing □Stabbing □Throbbing □Sharp □Dull □Superficial □Deep □Occasional □Frequent □Constant

6) **What activities make your symptoms worse?** □Sitting □Standing □Lying Down □Walking □Lifting □Carrying □Twisting □Bending/Squatting □Pushing/Pulling □Gripping □Squeezing □Throwing □ROM □Exercise □Computer Use □Changing Clothes □Getting Out of Bed Going from Sit to Stand □Upstairs □Downstairs □Morning □Daytime □Nighttime □Cold Weather □Damp Weather □Other:_____

7) **What have you tried to alleviate problem?** □Sitting □Standing □Lying Down □Changing Positions □Heat □Ice □Rest □Elevation □Exercise □Stretching □Limit Weight Bearing □Therapy □Chiropractic Care □Over The Counter Medications □Narcotics □Other Medication:_____ □Injections □Bracing □Splint □Sling □Other:_____

8) **Was anything successful at alleviating the problem**: □Sitting □Standing □Lying Down □Changing Positions □Heat □Ice □Rest □Elevation □Exercise □Stretching □Limit Weight Bearing □Therapy □Chiropractic Care □Over The Counter Medications □Narcotics □Other Medication □Injections □Bracing □Splint □Sling □Other:_____

Patient Name:_____ Patient Date of Birth:_____

Please list ANY drug allergies:_____

List Medication: (If possible, attach a list of medications)

Name of Med	Dosage	Frequency

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1) **Do you have any medical problems?** If so, please check from the list below: □Anemia □Anxiety/Depression □Arthritis □Asthma □Bleeding Disorder □Blood Clot □Blood Transfusion □Cancer
□Coronary Artery Disease □Diabetes □Gout □Heart Attack(MI) □Hepatitis □High Cholesterol □Hypertension □Kidney Disorder □Pacemaker □Pulmonary Embolism □Stroke □Ulcers
□Other:_____

2) **Have you ever had surgery?** Yes / No
If yes, please list surgery type and date: _____

3) **Have you previously had an injury to the affected body part you are being seen for today?** No / Yes
If yes, please explain: _____

4) In the past 60 days, have you experienced any of the following symptoms: □heartburn □nausea □vomiting □blood in stool □excessive thirst □heat or cold intolerance □weight loss □fever □blurred vision
□double vision □vision loss □ hearing loss □hoarseness □trouble swallowing □chest pain □palpitations □chronic cough □shortness of breath □painful urination □blood in urine
If any of these have been marked, please explain:_____

Family History:

Have any of your direct relatives had any of the following? Please check all that apply and indicate whether it was your Mother (by circling M) or Father (by circling F)
□Anemia-M/F □Anxiety/Depression-M/F □Arthritis-M/F □Asthma-M/F □Bleeding Disorder-M/F □Blood Clot-M/F □Blood Transfusion-M/F □Cancer-M/F □Coronary Artery Disease-M/F □Diabetes-M/F □Gout-M/F □Heart Attack(MI)-M/F □Hepatitis-M/F □High Cholesterol-M/F □Hypertension-M/F □Kidney Disorder-M/F □Pacemaker-M/F □Pulmonary Embolism-M/F □Stroke-M/F □Ulcers-M/F
□Other-M/F:_____

Patient Name:_____ Patient Date of Birth:_____

Have any of your direct relatives had any of the following? Please check all that apply and indicate whether it was your Brother (by circling B) or Sister (by circling S).

□Anemia-B/S □Anxiety/Depression-B/S □Arthritis-B/S □Asthma-B/S □Bleeding Disorder-B/S □Blood Clot-B/S □Blood Transfusion-B/S □Cancer-B/S □Coronary Artery Disease-B/S □Diabetes-B/S □Gout-B/S □Heart Attack(MI)-B/S □Hepatitis-B/S □High Cholesterol-B/S □Hypertension-B/S □Kidney Disorder-B/S □Pacemaker-B/S □Pulmonary Embolism-B/S □Stroke-B/S □Ulcers-B/S □Other-B/S:_____

Social History:

Do you use tobacco products? □No □Yes *Packs per Day: _____ Years of Use: _____

Do you use alcohol? □Yes □No

Occupation: _____ **Employer**: _____

Are you currently working? No / Part Time with Restriction / Full Time with Regular Duties

Patient Name:_____ Patient Date of Birth:_____

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HIPAA Notice of Privacy Practices

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 or condition and related health care services.

1. Uses and Disclosures of Protected Health Information
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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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 activities, employee review activities, training of medical students, licensing, 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.
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, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of 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 this 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.

Patient Name:_____ Patient Date of Birth:_____

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HIPAA Notice of Privacy Practices

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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 for the purposes of treatment, payment or healthcare operations. 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.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications 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 may have the right to have your physician amend 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 we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.
Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

Patient Name:_____ Patient Date of Birth:_____

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Brian Kindl, MD

OFFICE POLICIES

APPOINTMENTS

_____(Initial) I acknowledge that there is a $40 fee for a missed appointment or late cancellation. The no show fee will be enforced if an appointment is not cancelled or rescheduled within 24 hours prior to the appointment time. The no show fee **WILL** be expected to be paid **PRIOR** to being seen by the Doctor at the next visit.

PAIN MEDICATION

_____(Initial) I acknowledge that pain medication will only be given to me by this practice and I will not accept pain medication from any other providers without prior approval from this office. Also, I further acknowledge that pain medication will not be given to me **WITHOUT** an appointment.

NO refills will be given over the phone. So, please make sure you check prescriptions prior to leaving the office. **NO EXCEPTIONS WILL BE MADE**.

PAYMENTS

_____(Initial) I understand that I am responsible to keep my account up to date. Co-pays and co-insurances are expected at the time of each visit, and I understand that is a contract between myself and my insurance company. I further understand that if I have a balance for any reason it will be expected to be **PAID IN FULL** prior to or at my next appointment unless prior arrangements have been made. If no prior arrangements have been made and you are unwilling to pay the balance at the appointment, you will be asked to reschedule and possibly incur the $40 late cancellation charge.

FORMS

_____(Initial) I acknowledge that there will be a $25 form fee for any forms that need to be completed by the office, this would include but is not limited to… disability paperwork, insurance forms, work verification and etc. Forms will **NOT** be released if fee is not paid. ***All paperwork will be addressed within 7-10 business days***

I have read and understand all of the above office policies and procedures.

_____ _____

Patient Signature Date