AMBLER CHIROPRACTIC
Dr. Michael A. Coppola

Today's date: ________________ Birth Date: ____________________

Name: ____ Male______ Female______

Home address: ____

City, State, Zip: ____

Home phone: ____________________ Cell phone: ____________________

Email address: ____

Marital Status: Single___ Married___ Divorced ___Widowed ___ Number of children: _______

Occupation: ____ Work phone: _________________

How did you hear about us? ____

Emergency contact: ______________________________ Contact's Phone: ______________________

Insurance Information:

Subscriber Name: ____

Subscriber date of birth: _______________Relationship to Subscriber:_________________________

Subscriber Address (if different than patients): ____

Reason for Visit:

Have you ever been treated by a chiropractor before? ____

If so, please explain: ____

Reason for this visit: (Please circle) work; sports; auto, trauma; chronic

Please explain the pain and its location: ____

When did the condition begin? ____

Is the condition getting worse? Yes ____ No____ Constant ____ Comes/Goes ____

Is this condition interfering with your (Please circle) work; sleep; daily routine

If so, please explain: ____

Have you ever been treated by a Medical Physician for this condition? Yes ____ No___

If so, where? ____

Please list any other serious medical condition(s) you have or had: ____

____

Please list any allergies you may have: ____

List previous surgeries/treatments and include dates: ________________________________

Do you smoke? Yes____ No ____ How much? _________ how long have you smoked? ___________

Are you wearing? (circle all that apply): heel lifts; sole lifts; inner soles; or arch supports

Age of your mattress: ________________________

Other comments: ____

Health History

Are you taking any of the following medications? ___Nerve pills ___Pain killers (including aspirin) ___Muscle relaxers ___Stimulants ___Blood thinners ___Tranquilizers ___Insulin ___ Other(s)

Check any of the following you have or have had in the past 6 months:

Musculo-Skeletal
- __Low Back Pain
- __Pain Between Shoulders
- __Arm Pain
- __Joint Pain Stiffness
- __Walking Problems
- __Difficult Chewing /Clicking Jaw
- __Arthritis

Nervous System
- __Numbness
- __Paralysis
- __Dizziness
- __Forgetfulness
- __Confusion/Depression
- __Fainting
- __Convulsions
- __Cold/Tingling Extremities
- __Nervousness
- __Tremors

General Symptoms
- __Headache
- __Loss of Sleep
- __Fever
- __Fatigue
- __Foot Problems
- __Bruising easily
- __Gas/Bloating after Meals
- __Heartburn
- __Black/Bloody stool
- __Colitis

Cardiovascular
- __Chest Pain
- __Short Breath
- __Blood Pressure Problems
- __Irregular Heartbeat
- __Heart Problems
- __Lung Problems/Congestion
- __Varicose Veins
- __Ankle swelling
- __Stroke

Genito-Urinary
- __Bladder Trouble
- __Painful/Excessive Urination
- __Discolored Urine
- __Prostate/Sexual Dysfunction

Eye-Ear-Nose-Throat
- __Allergy
- __Vision problems
- __Dental problems
- __Sore Throat
- __Ear Aches
- __Hearing Difficulty
- __Stuffed Nose

For Women Only
- __Menstrual Irregularity
- __Menstrual Cramping or Backache
- __Infections
- __Breast Pain/Lumps

When was your last period? __________

Are you pregnant? ____yes ____no ____maybe

Gastro-Intestinal
- __Poor/Excessive Appetite
- __Excessive Thirst
- __Frequent Nausea
- __Vomiting
- __Diarrhea
- __Constipation
- __Hemorrhoids
- __Liver trouble
- __Gall Bladder problems
- __Weight Trouble
- __Abdominal Cramps
- __Abdominal Cramps

- We invite you to discuss with us any question regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy required payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and o financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary service needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any change in my medical status.

Signature______________________________________ **Date**_______/_______/_______

Ambler Chiropractic

Notice of Privacy Practices

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996. (HIPAA)

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.

Uses and Disclosures

There are a number of situations where we may use or disclose to other persons or entities your confidential medical information. Certain uses and disclosures will require you to sign an Acknowledgement that you received our Notice of Privacy Practices, including treatment, payment and health care operations. Any use or disclosure of your protected health information for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures required by law or under emergency circumstances, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

Use and Disclosures without Patient Acknowledgement of this Notice

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes: Treatment: We will use your medical information to make decisions about the provision, coordination or management of your health care, including diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your medical information with another health care provider whom we need to consult with respect to your care. We may also disclose certain information to a pharmacist for the purpose of filling a prescription for you, to a physical therapist to provide physical therapy under appropriate circumstances, or to a facility or other provider should you require surgery or other hospital care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your medical record to obtain reimbursement from you or your health insurance plan, or another insurer for our services rendered to you. This may also include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for purposes of reimbursement. This information may also be used for billing, claims management and collection purposes together with related health care data processing through our system.

Operations: Your medical records may be used in our business planning and development operations, including improvements in our methods of operations, and general administrative functions We may also use the information in our overall compliance planning, medical review activities, and arranging for legal auditing functions.

Use and Disclosure Without Acknowledgement or Authorization

There are certain circumstances under which we may use or disclose your medical information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings and in the event of death. Specifically, we are required to report to certain agencies information concerning certain communicable disease, sexually transmitted diseases and HIV/AIDS status. We are also required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law enforcement officials information that you or another person are in immediate threat of danger to your health or safety as a result of violent activity. We must also provide medical record information when ordered by a court of law to do so.

Authorization for Use or Disclosure

Except as outlined in the above sections, your medical information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to government entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental health treatment, drug and alcohol abuse, HIV/AIDS, or sexually transmitted diseases which may be contained in your medical records. We likewise will not disclose your medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

Additional Uses and Disclosures

We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Individual Rights

You have certain rights with respect to your medical record information, as follows:

1. You may request that we restrict the uses and disclosures of your medical records. Information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction;

   However, if we agree, we will comply with it, except otherwise required by law to make a full disclosure without restriction.
2. You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you will be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
3. You have the right to inspect, copy and request amendment to your medical records. Access to your medical records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding or for which your access is otherwise restricted by law. We will charge a reasonable fee for providing a copy of your medical records, or summary of those records, at your request, which includes the cost of copying, postage or preparation of an explanation or summary of the information.
4. All requests for inspection, copying and/or amending information in your medical records must be made in writing and be addressed to our "Privacy Officer" at our address. We will respond to your request in a timely fashion.
5. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your medical records information except for disclosures that require authorizations, disclosures incidental to another permissible use or disclosure, and otherwise allowed by law. We will not charge you for the first accounting in any 12 month period: however, we will charge you a reasonable fee for each subsequent request for accounting within the same 12 month period.
6. You have the right to obtain a paper copy of this notice if the notice was initially provided to you electronically, and to take one home with you if you wish.
7. All requests related to your rights herein must be made in writing and addressed to "Privacy Officer" at the address noted below.

Our Duties

We have the following duties with respect to the maintenance, use and disclosure of your medical records.

1. We are required by law to maintain the privacy of the protected health information in your medical records and to provide you with this Notice of its legal duties and privacy practices with respect to that information.
2. We are required to abide by the terms of this Notice currently in effect.
3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and medical records we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

Complaints

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your medical records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of a complaint to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints on line at the government's website: http://www.hhs.gov/ocr/hipaa.

Contact Person

All questions concerning this Notice or requests made pursuant to it should be addressed to:

Privacy Officer
Michael A. Coppola, D.C.
1005 Penllyn Pike
P.O. Box 509
Spring House, PA 19477
215-643-2250

Effective Date

This notice is effective April 14, 2003 and applies to all protected health information contained in your medical records maintained by us.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Ambler Chiropractic's Notice of Privacy Practice for protected health information.

Date:__________ Patient Name:______________________________
Print name

Signature of patient/Personal representative______________________________

Documentation of Good Faith Effort to Obtain Written Acknowledgement:

I made a good faith effort to obtain the patient's written acknowledgement of our notice of Privacy Practices for protected health information by (check all that apply):

___Showing the patient the Notice of Privacy Practices posted in our office.

___Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.

___Asking the patient to sign this acknowledgement form.

___Other (explain in detail)______________________________
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Witness______________________ Date______________