EPOCH CHIROPRACTIC

n. [ep-uh k] 1. a point in time beginning a new or distinctive period.

5231 W. Woodmill Dr. Wilmington, DE 19808 | p: 302.635.7421 | f: 302.635.7422 | www.epochchiro.com

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

How did you hear about us? _____ [Staff Notes:_____]

Patient Information ***PLEASE COMPLETE ALL FIELDS (INDICATE "N/A" ON FIELDS THAT DO NOT APPLY)***

Address:_____

City:_____

State:_____ Zip:_____

Email: _____

Cell:_____Home: _____

Work:_____

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

☐ Single ☐ Married ☐ Divorced ☐ Other

Patient Employer/ School:_____

Occupation:_____

Employer/ School Address:_____

_____

Employer/ School Phone: _____

Spouse's Name:_____

Birth Date:_____

Spouse's Employer:_____

In Case of Emergency, contact:

Name:_____

Phone: _____ Relationship:_____

Primary Care Physician Information

Physician Name: _____

Practice: _____

Phone: _____ Date of last visit: _____

Reason For Visit: _____

Family Information

Children's Name(s)	Sex(M/F)	Age

Insurance Information

Who is responsible for this account: _____

Relationship to patient: _____

Card Holders Birth date: _____

Is there additional/secondary insurance?

☐ Yes _____ ☐ No

- - - - - - - - - - [**OFFICE STAFF**] - - - - - - - - - - - -

Insurance Co. _____

Patient ID #_____ Group#_____

Patient Condition

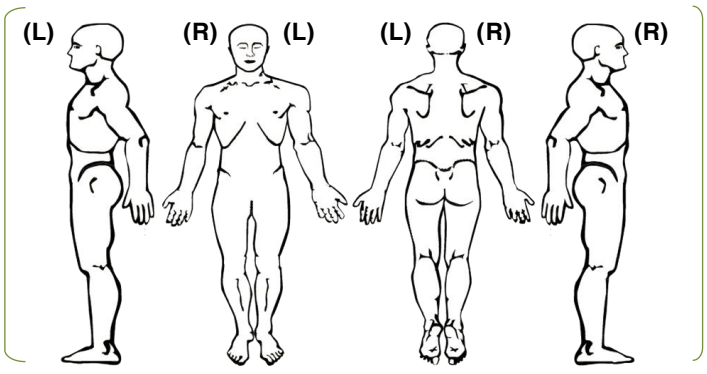
Reason(s) for Visit (in order of main concern)

1. _____ ***Check all that apply:*** ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Swelling ☐ Shooting ☐ Burning ☐ Cramps ☐ Tingling ☐ Stiffness ☐ Other: _____

2. _____ ***Check all that apply:*** ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Swelling ☐ Shooting ☐ Burning ☐ Cramps ☐ Tingling ☐ Stiffness ☐ Other: _____

3. _____ ***Check all that apply:*** ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Swelling ☐ Shooting ☐ Burning ☐ Cramps ☐ Tingling ☐ Stiffness ☐ Other: _____

Please circle all area(s) of concern:



***VAS*: Please circle the number that BEST represents your condition**

0 = NO pain 10 = Worst Possible Pain

|------|------|------|------|------|------|------|------|------|------|------|

0 1 2 3 4 5 6 7 8 9 10

Patient Condition Continued **PLEASE COMPLETE ALL FIELDS (INDICATE "N/A" ON FIELDS THAT DO NOT APPLY)**

Answer the following for your MAIN concern:

Is this a result of a car accident or injury at work? ☐ *Yes (Date of accident/injury:_____)* ☐ *No*

***** If yes, STOP and see staff. *****

When did your symptoms appear? _____

What do you believe caused this problem? _____

Is this condition: ☐ Getting Better ☐ Getting Worse ☐ Unchanged

Have you had this before? ☐ Yes ☐ No Last Occurrence? _____

How often do you have this pain? ☐ Constant ☐ Intermittent ☐ Only with certain movements/positions ☐ Random

What makes it better? _____

What makes it worse? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other: _____

Activities/movements painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Other: _____

Lifestyle **PLEASE CHECK ALL THAT APPLY**

Exercise	Work Activity	Habits	Sleep
☐ None ☐ Light/Sporadic ☐ Moderate ☐ Heavy	☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor	☐ Current Smoker: _____yrs _____packs/day ☐ Former Smoker: _____yrs / _____yrs quit ☐ Alcohol (circle): social | moderate | heavy ☐ Coffee/Caffeine: _____cups/day ☐ Stress Level (0-10): _____	☐ Average hours of sleep / night _____ ☐ Trouble falling / Staying asleep ☐ Restless Sleep Sleeping position: (check all that apply) ☐ RT Side ☐ LT Side ☐ Stomach ☐ Back

DESCRIBE TYPE(S) OF EXERCISE: _____

Health History

Name and phone number of other doctor(s) who have treated you for your condition: _____ ☐ NONE

Last time you were seen by a Doctor of Chiropractic? _____ ☐ N/A

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Massage ☐ Chiropractic Services ☐ NONE ☐ Other: _____

Please list all injuries/surgeries you have had: **Description:** **Date:**

Car Accident(s): _____

Falls: _____

Head Injuries/Concussions: _____

Broken Bones/Fractures/Dislocations: _____

Surgeries (provide additional list if >3): _____

Please mark "Yes" or "No" to indicate if you have had any of the following:

☐Yes ☐No AIDS / HIV	☐Yes ☐No Diarrhea	☐Yes ☐No Herniated Disc	☐Yes ☐No Osteoporosis
☐Yes ☐No Alcohol / Drug Abuse	☐Yes ☐No Eczema	☐Yes ☐No High Blood Pressure	☐Yes ☐No Pacemaker
☐Yes ☐No Allergies	☐Yes ☐No Eating Disorder	☐Yes ☐No High Cholesterol	☐Yes ☐No Parkinson's
☐Yes ☐No Anemia	☐Yes ☐No Emphysema	☐Yes ☐No Irritable Bowel Syndrome	☐Yes ☐No Pinched Nerve
☐Yes ☐No Arthritis	☐Yes ☐No Epilepsy / Seizures	☐Yes ☐No Kidney Disease / Stones	☐Yes ☐No Pneumonia
☐Yes ☐No Asthma	☐Yes ☐No Fibromyalgia	☐Yes ☐No Liver Disease	☐Yes ☐No Polio
☐Yes ☐No Autoimmune Disease	☐Yes ☐No Frequent colds/ Infections	☐Yes ☐No Low Blood Sugar	☐Yes ☐No Psychiatric Disorder
☐Yes ☐No Back Pain / Injury	☐Yes ☐No Gallbladder Issues/stones	☐Yes ☐No Lyme Disease	☐Yes ☐No Rheumatoid Arthritis
☐Yes ☐No Bleeding Disorder	☐Yes ☐No Glaucoma	☐Yes ☐No Measles	☐Yes ☐No Rheumatic Fever
☐Yes ☐No Cancer	☐Yes ☐No Gout	☐Yes ☐No Menopause	☐Yes ☐No Ringing in Ears
☐Yes ☐No Chicken Pox	☐Yes ☐No Hashimoto's	☐Yes ☐No Menstrual Issues / PMS	☐Yes ☐No Skin Disorder(s)
☐Yes ☐No Cold Sores	☐Yes ☐No Headache / Migraine	☐Yes ☐No Miscarriage	☐Yes ☐No Stroke
☐Yes ☐No Constipation	☐Yes ☐No Heart Disease / Attack	☐Yes ☐No Multiple Sclerosis	☐Yes ☐No Thyroid Problem
☐Yes ☐No Celiac Disease	☐Yes ☐No Hepatitis	☐Yes ☐No Mumps	☐Yes ☐No Ulcers
☐Yes ☐No Diabetes	☐Yes ☐No Hernia	☐Yes ☐No Neck Pain / Injury	☐Yes ☐No Venereal Disease (STD)

Others not listed above: _____

Medication (provide additional list if > 4)

Medications	Allergies	Vitamins/Supplements
MARK N/A IF NOT APPLICABLE	**MARK N/A IF NOT APPLICABLE**	**MARK N/A IF NOT APPLICABLE**
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.

Pharmacy Name: _____

Pharmacy Phone: _____

Family Health History **PLEASE CHECK ALL THAT APPLY

Condition/Disease	Family Member/Relation	Condition/Disease	Family Member/Relation
☐ Alzheimer's/ Dementia:		☐ Liver Disease:	
☐ Anxiety:		☐ Migraines/Headaches:	
☐ Arthritis:		☐ Obesity:	
☐ Autoimmune Disease(s):		☐ Osteoporosis:	
☐ Blood Clotting Problems:		☐ Psychiatric Disorders:	
☐ Celiac Disease:		☐ Thyroid Disorder:	
☐ Depression:		☐ Heart Disease:	
☐ Diabetes:		☐ Stroke:	
☐ High Blood Pressure:		☐ Cancer (list all types):	
☐ High Cholesterol:			
☐ Inflammatory Arthritis:			
☐ Kidney Disease:		☐ Other:	

Check here if NONE of the above apply ☐

List family member and age at death (if deceased): _____

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that Epoch Chiropractic may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Epoch Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that I am responsible for all attorney fees or collection fees related to the collection of my account. I agree to pay interest at the rate of 1.5% per month (18% per annum) on any unpaid balance.

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and potential for improvement.

Signature: _____ Date: _____

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Informed Consent for Chiropractic Treatment

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health is a state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.**

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name	Signature	Date
Doctor signature		Date

Minors only:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Parent/Guardian Signature Date

Females only: Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual cycle: _____

Signature Date

ASSIGNMENT, LIEN, AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY

To whom it may concern:

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Eternal Health LLC, doing business as Epoch Chiropractic, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor or clinic's expense.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient: _____ Date: _____

Epoch Staff: _____ Date: _____

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Notice of Privacy Practices

The privacy of your medical information is important to us and we are committed to protecting it. This notice describes how information about you may be used and disclosed, as well as, how you can get access to this information. Please read this information carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations. These include emergency care, quality assurance activities, payment, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a written request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We have the right to make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services.

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
Eternal Health LLC at Epoch Chiropractic
5231 W. Woodmill Dr.
Wilmington, DE 19808
302.635.7421

I, Hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____ Date: _____

Effective Date: This notice is effective October, 1 2011 and applies to all protected health information contained in your medical records maintained by us.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ **DOB**: _____

I hereby request and authorize: **Epoch Chiropractic** – Eternal Health, LLC

☐ *To disclose* information to: ☐ *To receive* information from:

Provider/Office: _____

Phone/Fax: _____

Information to be disclosed will include copies of:

☐ Entire Record ☐ All Imaging Reports/CDs ☐ Progress Notes

☐ Physical Exam Forms ☐ Daily Chart Notes ☐ Lab Results

☐ Other: _____

HIV/AIDS testing, drug and alcohol information, and psychological/psychiatric studies will be included in this request unless otherwise indicated: ☐ Do not release

Purpose of Request: ☐ Continuation of Care ☐ Patient Request

☐ Other: _____

I understand this authorization will be effective for **six months after the date signed**, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation.

I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

_____ _____

Signature of Patient or Representative Date

_____ _____

Witness Date