OUR MISSION STATEMENT

To be able to help as many people as we can, reach their potential, especially children

We are encouraging all our patients to help us in this most important and noble mission.

HIPPA Happenings at Better Health Chiropractic

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

Our Promise to You, Our Valued Patient...

We want to assure you that we take the new Federal HIPAA (Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our office because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why A Privacy Policy Now ?

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of electronic technology in the health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review how your information is used within our computers, internet, phones, fax machines, and any device used to copy or transfer that data. We want to advise you that we have developed policies and procedures for our practice to assure that your personal health information will be shared only as required for the purpose of administering your care. Our office is subject to State and Federal laws regarding the confidentiality of your health information and we promise our adherence to those laws. We also want you to understand our procedures and your rights as a valued patient. Your health information will be communicated only for the purpose of conducting health care business and obtaining payment for services. Be assured that without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used To Provide Treatment

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories, or other health professionals providing you treatment.

To Obtain Payment

Your health information may be included with an invoice in order to collect payment for the services provided to you in this office. We may do this with insurance forms filed for you electronically or by mail. We will make every effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations to our staff. Some of the best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, and associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during insurance company audits or by government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing, or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you and your family. These communications are an important part of our philosophy, which is to partner with our patients to see they receive the best chiropractic care we can provide. This may include postcards, newsletters, flyers, and telephone or electronic reminders such as e-mail (unless you tell us that you prefer not to receive reminders).

Public Health and National Security

We may be required to disclose necessary health information to Federal officials or military authorities in order to complete investigations related to public health and or national security.

For Law Enforcement

As permitted or required by State and Federal law, we may disclose your health information under certain circumstances to proper authorities for the purpose of law enforcement. This may take place if you are a victim of a crime, or in order to report a suspected crime.

Family, Friends and Care Givers

We may share your health information with those that assist you with your home hygiene, care, treatment, or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, if you are unable communicate your wishes, we will use our very best judgement when sharing your health information with anyone participating in your care.

Medical Research
Advancing health care knowledge often involves learning from the careful study of health histories of prior patients. Formal review and study of health histories will transpire only under the ethical guidance, requirements, and approval of an Institution Review Board.

Authorization to Use or Disclose Heath Information
Other than the information stated above, or information that Federal, State, and Local laws require, we will not disclose your health information without your written authorization. You may revoke that authorization in writing at any time.

Patient Rights
This law is careful to describe that you have rights related to you health Information. Be assured that our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications
You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately, with or without other family members present, or through sealed mail communications. We will make all reasonable efforts to honor your request.

Inspect and Copy Your Health Information
You have the right to read, review, and copy your health information. This Includes your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request. Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested, sealed, and or delivered to any authority for review.

Documentation of Health Information
You have the right to request a description of how our office used your health information for reasons other than treatment, payment, or health care operations. Our documentation procedure will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We greatly appreciate your limited request for no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of This Notice
You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. We are required by law to maintain privacy of our health information and provide to you or your representative this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. Patients will be notified of any such changes. You have the right to express concerns or complaints to any staff member of Better Health Chiropractic, or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing any concerns you may have regarding the privacy of your health information.

Patient Acknowledgment

Patient Name(s):

_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have questions, please let us know. If not, we would appreciate your acknowledgments that you have received, thoroughly reviewed, and understand this policy by signing on the line below. Thank you.

_____ _____

Patient Signature Date

Patient Introduction

Personal History:

Your Name: _____
First Middle Last

Your Address:
_____
_____
_____

Telephone: Home:_____ Bus: _____

Insurance Card: _____
(Please bring health card to front desk)

Birth Date: Month: _____ Day: _____ Year: _____

Social Security Number: _____

E-Mail Address:_____

Marital Status:_____

Occupation: _____

Employer: _____

Previous Chiropractor: _____ City: _____

Last visit to this Chiropractor:_____

Reason for leaving:
_____
_____
_____

Present MD: _____ City: _____

Referred to our Centre by:
_____

Our Fee Structure

Please note our fees for your initial visit:

Consultation	Complimentary
Examination	$ 56.00
Radiology	Variable (up to a maximum of $150.00)

Please note that if you have been involved in a motor vehicle accident, our fee structure may differ due to the complexity of your needs in such cases.

Please also note that your clinical Report of Findings, the time that your doctor will spend with you to go over your results.

I fully understand the above fees and give my consent. I also give my consent to have the doctor take any x-rays he/she deems appropriate to better understand my problem and monitor my progress.

SIGNATURE: _____ DATE: _____

(Signature of Parent/Guardian required if patient under age 18)

Thank You!

CONSENT FOR TREATMENT OF MINOR CHILD

I HEREBY AUTHORIZE DR JEFFEREY G. BEAVERS, D.C. AND WHOMEVER HE MAY DESIGNATE AS ASSISTANTS TO ADMINISTER CHIROPRACTIC CARE AS DEEMED NECESSARY TO MY: _____ (RELATIONSHIP)

DATED AT _____ (CITY / STATE)

SIGNATURE _____ (PARENT/GUARDIAN)

DATE _____ (MONTH/DAY/YEAR)

BEAVERS BETTER HEALTH CHIROPRACTIC, INC.
Dr. Jefferey G. Beavers, D.C.

Initial Child & Adolescent Questionnaire

Your Name: _____, Your Mom: _____

Your Dad: _____

Mainly for Moms:

1. Tell us about your pregnancy;

Did you carry to full term? _____

Describe any complications and when they occurred: _____
_____
_____

2. Tell us about your delivery and birth of this child:

Did you use a midwife? _____ Hospital? _____ Obstetrician?_____

Did you have a C-Section? _____ Were forceps used?_____

Vacuum Extraction? _____ Were you induced? _____

Did you have an Epidural? _____ Was it a difficult birth?_____

What was the baby's **APGAR** Score? _____ at 5 minutes? _____

3. Tell us more:

Did you breastfeed? _____ How long? _____ What formula after?_____

Did you consume alcohol during your pregnancy? _____ How much? _____

Did you smoke? _____ How much? _____ How long?_____

Did you take any medication during your pregnancy?

For what? _____ What type?_____

Any exposures to ultrasound?_____, How many?_____

4. As a baby/toddler, (birth to 4 years), did any of the following occur?

___ Fall from a change table
___ Tumble down stairs
___ Fall out of crib
___ Involved in car accident
___ Fall off playground equipment
___ Play in "Jolly Jumper"
___ Frequent ear infections
___ Tonsilitis
___ Reaction to vaccination
___ Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Sleeping problems
___ Frequent colds
___ Colic
___ Did not gain weight
___ Other_____

Please explain the above: _____
_____
_____

5. As a young child, (5-12 years), did any of the following occur?

___ Fall from a tree
___ Fall of a bicycle
___ Fall of playground equipment
___ Sports accident
___ Car accident
___ Stomach pains
___ Scoliosis
___ Bed wetting
___ Hyperactivity/Autism
___ Learning difficulties
___ Asthma
___ Allergies
___ Leg/knee pains
___ Other_____

Please explain the above: _____
_____
_____

6. Tell us about any vaccinations your child has had: _____
_____
_____

Any reactions to any of these? _____
_____

Were you told that you had a choice in vaccinating your child? ___**YES**, ___**NO**
Would you like information on the "other side" of this issue? ___**YES** ___**NO**

7. As a child or adolescent, has your child experienced any of the following:

___ Headaches
___ Dizziness
___ Ringing in ears
___ Asthma
___ Hyperactivity
___ Fatigue
___ Numbness in arms/hands
___ Arm/wrist pains
___ Sleeping problems
___ Allergies
___ Stomach problems
___ Weight gain/loss
___ Foot/ankle/knee pains
___ Tingling in arms/legs
___ Neck/back pains
___ Shoulder pains
___ "Growing Pains"
___ Other _____

Please explain any of the above: _____
_____
_____

8. **Which of the problems you have checked off is the worst?** _____

_____

Is this problem: Constant __, Intermittent __, Occasional __, Cyclic ___

9. **How long has it persisted?** _____

10. **When it is at its worst, how does it make your child feel?** _____

11. **What have you done about it that has NOT worked?** _____

_____

_____

12. **What makes it worse?** _____

13. **What effect does this problem have of your child's body functions?**

_____

_____

On his/her participation in daily activities? _____

14. **Describe any hospital stays:** _____

_____

15. **Approximately how many times have antibiotics been prescribed and for what conditions?** _____

_____

16. **List any medications your child is currently taking:** _____

_____

17. **To summarize, what is your purpose for this appointment?** _____

_____

_____

18. **Is there anything else you feel we should know?** _____

_____

_____

_____

Signature of parent or guardian: _____

Date: _____

***

FAMILY HEALTH HISTORY

Patient Name: _____ **Date:** _____

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Siblings		Children		
	Age	Age	Age	Age	Age	Age	Age	Age
ADHD								
Allergies								
Arthritis								
Asthma								
Autism								
Back Trouble								
Bed Wetting								
Bursitis								
Cancer								
Chest Pain								
Colic								
Constipation								
Crohn Disease								
Depression								
Diabetes								
Diarrhea								
Disc Problems								
Down Syndrome								
Ear Infection								
Emotion Issues								
Emphysema								
Epilepsy								
Headaches								
Migraines								
Heartburn								
Heart Trouble								
High Blood Press								
IBS								
Indigestion								
Infertility								
Insomnia								
Kidney Trouble								
Neck Pain								
Neuritis								
Nervousness								
Pinched Nerve								
Scoliosis								
Sinus Trouble								
Other								

Additional Comments:

_____

_____

_____

Thank you!