Sampson Chiropractic and Sports Injuries

Patient Health History

Today's Date / / **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____ **Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other

SSN _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

How did you hear about Sampson Chiropractic?_____

Verification Question: In what city were you born?

Verification Answer: _____

Continued ...

Sampson Chiropractic

948 N. Suncoast Blvd.
Crystal River, FL 34429
Telephone (352) 564-0460
www.sampsonchiropractic.com

PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____
ADDRESS _____CITY _____ STATE ___ ZIP CODE _____
HOME PHONE _____ CELL # _____EMAIL _____
SOCIAL SECURITY NUMBER _____ MARITAL STATUS: M S D W NUMBER OF CHILDREN ____
SPOUSE'S NAME _____ EMERGENCY CONTACT # _____
EMPLOYER _____ EMPLOYER PHONE NUMBER _____
OCCUPATION _____
HOW DID YOU HEAR ABOUT SAMPSON CHIROPRACTIC? _____

ARE YOU HERE FOR A WORK RELATED INJURY? Y or N ____ *FILL OUT SECTION A*
ARE YOU HERE FOR AN AUTO ACCIDENT? Y or N ____ *FILL OUT SECTION B*

SECTION A – WORKERS COMPENSATION INFORMATION

DATE OF INJURY _____ TIME OF INJURY _____ EMPLOYER'S NAME _____
EMPLOYER'S ADDRESS _____ CITY _____ STATE _____ ZIP _____
EMPLOYER'S PHONE _____ SUPERVISOR _____
NAME OF INSURANCE COMPANY _____ INSURANCE PHONE _____
COMPENSABLE INJURIES _____ DESCRIPTION OF INJURY _____
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING AS A RESULT OF YOUR INJURIES?

☐ Ringing in your ears	☐ Tingling	☐ Nausea
☐ Blurred or distorted vision	☐ Bleeding	☐ Vomiting
☐ Numbness	☐ Dizziness	☐ Headaches

SECTION B – AUTO ACCIDENT INFORMATION

DATE OF INJURY _____ TIME OF ACCIDENT _____ ARE YOU CURRENTLY OFF WORK (Y or N) _____
DESCRIBE THE INCIDENT _____
DID YOU LOOSE CONSCIOUSNESS? Y or N _____
WERE YOU EXAMINED AT A HOSPITAL OR ANOTHER CLINIC? Y or N ____ WHERE? _____
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING AS A RESULT OF YOUR INJURIES?

☐ Ringing in your ears	☐ Tingling	☐ Nausea
☐ Blurred or distorted vision	☐ Bleeding	☐ Vomiting
☐ Numbness	☐ Dizziness	☐ Headaches

By signing below:

- I hereby authorize the release of all my medical records to Sampson Chiropractic & Sports Injuries where necessary or as required for purposes of my examination and or treatment.

- I further authorize payment be made directly to Sampson Chiropractic & Sports Injuries as an assignment of my benefits for services rendered that would otherwise be payable to me.

- In the event that my outstanding bills are unpaid by a third-party source, I agree to be held responsible for payment of all services performed. Collection for unpaid services is at the discretion of Sampson Chiropractic & Sports Injuries.

- I have read and understand the above statements and attest that the information I have provided is correct.

_____ _____
PATIENT SIGNATURE

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MRI _____
NCV_____
BRAIN MAP_____

PATIENT HISTORY FORM

NAME _____ DATE _____

OCCUPATION: _____

DATE OF ONSET _____

CHIEF COMPLAINT

DESCRIPTION _____
_____
_____
_____
_____
_____

PROGRESS: WORSE SAME BETTER

PREVIOUS CARE FOR CHIEF COMPLAINT

NAME AND LOCATION OF DOCTOR _____
DATE ATTENDED _____ HOSPITAL _____
EXAMINATION AND X-RAYS _____
TYPE OF TREATMENT _____ RESULTS: GOOD FAIR POOR

PAST HISTORY

RECENT SURGERY _____
TREATMENT FOR OTHER CONDITION _____
PREVIOUS SERIOUS ILLNESS _____ FAMILY PHYSICIAN _____
HAVE YOU EVER BEEN DIAGNOSED WITH OSTEOPORSIS OR OSTEOPENIA? YES NO IF YES WHEN? _____

HABITS, DRUGS, AND VITAMINS

EXERCISE _____ TEA/COFFEE _____
MEDICATIONS _____
VITAMINS _____ DIET _____

MISCELLANEOUS

Do you have any other questions you would like to discuss with Dr Sampson? _____
_____
_____
_____

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Patient Informed Consent

We specialize in the treatment of spine, joint injuries, and associated pain. We perform various treatments consisting of passive modalities, therapeutic interventions, and spinal and extra-spinal manipulation. Our goal is to reduce and or eliminate your pain, however, as with any Chiropractic or physical medicine therapies there are inherent risks with the services we provide.

Passive Modalities: We use a variety of widely used therapeutic devices to complement our chiropractic treatments including interferential therapy, ice, moist heat, ultrasound, and cervical and lumbar traction. These modes of therapy are used to help reduce pain and inflammation, among other things.

Therapeutic Interventions: Therapeutic interventions consist of stretching, flexibility and strengthening exercises, range of motion exercises, joint mobilization and myofascial release.

These activities are generally safe though there are risks associated with each. The primary risk is potential aggravation of your condition. As with any physical activity there is always the risk of injury. Though this risk is minimal it may still exist.

Some adverse responses to therapeutic interventions include, but are not limited to: muscle soreness, bruising, muscle fatigue, increased pain and discomfort, and/or joint stiffness. It is important that you inform your treating staff member of any of these responses are more importantly it is crucial that you attend all of your scheduled appointments so that changes in your condition can be accurately documented and your symptoms effectively managed.

Spinal and Extra-spinal Manipulation: Chiropractic manipulation seeks to restore joint function to the spine and other joints of the body. Typically, this involves applying a specific, highly controlled treatment directly to a joint or muscle. This treatment often reduces and/or eliminates both local and referred pain, allows muscles to relax, and may even release the irritation from the nervous system, which may result in other health benefits. The following are some of the risks of manipulation.

- **Disc Herniations:** The occurrence of disc herniations as a result of spinal manipulation is very unlikely. Discs withstand an average of 23 degrees of rotation and a degenerative disc an average 14 degrees. Posterior facets of the spine limit rotation during manipulation to approximately 2-3 degrees.

- **Cauda Equina Syndrome:** The estimated incident rate of this complication as a result of lumbar manipulations approximately 1 in 100 million manipulations. The likelihood of this occurrence is possibly increased with the presence of herniated nucleus pulposus.

- **Vertebrobasilar Artery Compromise:** Chiropractic manipulation has been shown in isolated cases to result in stroke as a result of desiccation of the vertebral artery. The likelihood of such an event has been estimated at 1 in 1,000,000 cervical manipulations (Hurwitz, 1996; McGregor, 1995). Possible symptoms of stroke include, but are not limited to: dizziness, light-headedness, numbness, slurred speech, loss of consciousness, and memory or comprehension disturbances. If you have any of these symptoms following cervical manipulation, please contact us and/or seek immediate emergency medical treatment.

I have reviewed the information provided above regarding the benefits and risks of treatment provided in our offices. I have been given the opportunity to ask questions and/or discuss concerns. I acknowledge and accept the risks of my treatment.

Patient Name	Patient Signature	Date

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What to do and expect after therapy

We utilize a variety of different therapeutic methods to treat our patients and their injuries including interferential therapy, myofascial release, therapeutic exercise, ultrasound, moist heat, ice, paraffin, and traction. While the immediate goal of therapy is pain reduction, you may experience increased levels of pain during the initial phases of care. The following are common, non-complicating responses to therapy, soreness, bruising, stiffness, increased pain, and decreased joint mobility, and weakness.

If any of the above-mentioned responses occur or if anything arises which causes u concern, please tell one of our staff as soon as possible. While such results are common, they need to be documented and possible changes made to your treatment protocol.

Home Care: In order to reduce the likelihood that an adverse reaction occurs, we have provided you with a list of things to do at home.

- **Use ice –** Ice is an amazing anti-inflammatory. Myofascial release is a frequently used therapy in our office. Its function is to reduce muscle spasm, increase muscle function, and reduce scar tissue formation. Myofascial release is an intense therapy that may result in bruising and increased soreness. To reduce the likelihood of an adverse reaction from any therapy, please use ice and increase your water consumption.

- **Stretch** – We always advise that you incorporate stretching into your daily routine, unless otherwise advised by Dr. Sampson. Stretching will help your muscles stay loose and will reduce the stress on your joints.

- **Keep your appointments** – Your treatment plan requires that you stay consistent with your therapy. This will help minimize the number of therapy sessions and maximize your therapeutic gains. Keeping up with scheduled appointments also allows us to accurately track your progress.

- **Avoid activities that may aggravate your injury/condition –** Some injuries need to be fixed before they can be rehabilitated. You may do more harm than if you choose to participate in activities that we find contrary to your care. Activities of daily living may prove to be too much. You are less likely to suffer a serious setback if you are cautious and increase your activity level gradually.

In case of emergency: If a situation arises where you experience a serious adverse reaction to care or a significant side effect which you feel requires emergency medical attention, then go the closest emergency care center or call 911. Contact our office as soon as possible and keep us informed.

If you ever have questions concerning your injury or treatment, please do not hesitate to ask us.

Thank you,

SAMPSON CHIROPRACTIC

Patient Name	Patient Signature	Date

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Name: _____

Signature: _____

Date: _____

SIGNING THIS FORM LEAVES ME RESPONSIBLE FOR ALL CHARGES TO THE UNPAID BALANCE OF MY ACCOUNT.

DR. SAMPSON, D.C.

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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.

Uses and Disclosures

Some examples of how we may use or disclose your healthcare information:

- Your chiropractor or a staff member may disclose your health information to another healthcare provider, hospital, or treatment facility in order to refer you for diagnosis, assessment, treatment, or testing.
- Your chiropractor or a staff member may disclose your health information, including your billing records, to another party such as an insurance carrier, an HMO, a PPO, or your employer or their insurance carrier, if they are potentially responsible for the payment of the services your receive.
- Your chiropractor or a staff member may disclose your health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.
- You have the right to refuse us authorization to contact you to provide appointment reminders, information about your treatment alternatives, or other health related information that may be of interest to you. If you refuse us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.
- At any time, you may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information.

Permitted Uses and Disclosures Without Your Consent or Authorization

Under Federal law, we are permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- We are permitted to use or disclose your health information when required to do so by applicable federal or state laws.
- We are permitted to use or disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information to under state or federal law.
- We are permitted to use or disclose your health information to an appropriate governmental authority if we reasonably believe you are the victim of abuse, neglect, or domestic violence.
- We are permitted to use or disclose your health information for state and federal health oversight activities of the healthcare system and government benefit programs.
- We are permitted to use or disclose your health information to a law enforcement authority as required by laws to report certain types wounds or physical injuries or to comply with a court order, subpoena, or administrative request authorized by law.
- We are permitted to use or disclose your health information to a law enforcement authority if the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- We are permitted to use or disclose your health information to a correctional institution if we provide healthcare services to you as in inmate.
- We are permitted to use or disclose your health information if we provide healthcare services to you in an emergency.
- We are permitted to use or disclose your health information if we provide care to you that is related to a workplace injury to the extent necessary to comply with Worker's Compensation rules and regulations.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. Your revocation request will not be honored if:

- We have already released your health information before we receive your request to revoke your authorization.
- You were required to give your authorization as a condition of obtaining insurance; the insurance company may have a right to your health information if they decide to contest any of your claims.
- Any circumstance in which we are permitted or required to use or disclose your health information without your consent or authorization.

Your Right to Limit Use or Disclosure

If there are healthcare providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want use to disclose your health information, please let us know in writing which providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your healthcare information. We are not required to agree to your restriction; however, if we agree with your restriction, the restriction is binding on us. If we do not agree to your restriction, you may seek care from another healthcare provider.

Other than the circumstances described above, any other use or disclosure of your health information will only be made with your written authorization.

Patient Signature:_____ Date: _____

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Your right to receive confidential communication regarding your health information
We normally provide the information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information
You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing. We may refuse your request if the information is for use in a civil, criminal, or administrative acting or proceeding which is anticipated to occur in a time frame reasonable proximate to your request. There may be a cost associated with your request if we must copy information for you.

Your right to amend your health information
You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records
You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last 6 years before the date of your request. The accounting will include all disclosures except:

- Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- Those disclosures made to you.
- Those disclosures we are permitted to make without your consent or authorization as described above.
- Those disclosures made based on an authorization you signed.
- Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- Those disclosures for national security or intelligence purposes.
- Those disclosures made to correctional facilities or law enforcement officers.
- Those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your right to obtain a paper copy of this notice
If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our duties
We are required by law to maintain the privacy of your health insurance information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure
Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain
You may complain to us or the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be sent to us at the address listed above.

To contact us
If you would like further information about our privacy policies and practices, please contact us or visit our website.

Patient Signature:_____ Date: _____