____Patient I.D.

HEARTLAND FAMILY CHIROPRACTIC, PLLC

THANK YOU FOR CHOOSING HEARTLAND FAMILY CHIROPRACTIC, PLLC PLEASE COMPLETE ALL QUESTIONS.

NAME: ______________________ SOCIAL SECURITY #: ______________________

ADDRESS: ______________________ CITY: ____________ STATE: ________ ZIP: ________

PHONE #: ______________ Email: ______________________ BIRTHDATE: __________

EMPLOYER: ______________________ EMPLOYER'S PHONE #: ______________________

MARITAL STATUS: M S W D PREGNANT? YES NO # OF CHILDREN: __________

NAME OF SPOUSE OR GUARDIAN______________ SPOUSE'S EMPLOYER: ______________________

NAME& SOCIAL SECURITY # OF PERSON RESPONSIBLE FOR THIS ACCOUNT______________________

EMERGENCY CONTACT: ______________ RELATIONSHIP: ______________________

PHONE#:______________________ ALTERNATIVE PHONE #:______________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ______________________
IF YOU WERE REFERRED, WHOM MAY WE THANK? ______________________

IS THIS VISIT THE RESULT OF AN AUTO ACCIDENT OR WORK INJURY? YES OR NO
IF YES, DATE THAT THE INJURY OCCURRED __________ BRIEFLY DESCRIBE THE INCIDENT IN WHICH THE INJURY OCCURRED.

____

____

CURRENT HEALTH COMPLAINTS: **DATE STARTED OR HOW LONG/OFTEN?**

1.______________________ ______________________

2.______________________ ______________________

3.______________________ ______________________

FAMILY MEMBERS WITH SIMILAR PROBLEMS? YES OR NO IF SO, WHO? ______________________

MEDICAL DOCTORS OR CHIROPRACTORS YOU HAVE SEEN FOR THIS CURRENT PROBLEM:

NAME: ______________________ CONDITION: ______________________

NAME: ______________________ CONDITION: ______________________

NAME: ______________________ CONDITION: ______________________

HAVE YOU BEEN SEEN IN THIS OFFICE IN THE LAST THREE YEARS? YES OR NO
IF SO, FOR WHAT CONDITION? ______________________ DATE: ______________

CURRENT MEDICATIONS: **PREVIOUS SURGERIES**

NAME: ____________ PURPOSE: ____________ TYPE: ____________ DATE: ____________

NAME: ____________ PURPOSE: ____________ TYPE: ____________ DATE: ____________

NAME: ____________ PURPOSE: ____________ TYPE: ____________ DATE: ____________

DO YOU HAVE HEALTH INSURANCE? YES OR NO
NAME OF YOUR INSURANCE COMPANY: ______________________
NAME OF THE POLICY HOLDER: ______________________ POLICY HOLDER'S BIRTH DATE: __________

THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE AND GIVE MY CONSENT FOR DR. FULKERSON AND HIS ASSISTANTS TO ADMINISTER CHIROPRACTIC CARE AS DEEMED NECESSARY AND TO TAKE ANY NECESSARY X-RAYS. I FURTHER UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. FURTHERMORE, I UNDERSTAND THAT HEARTLAND FAMILY CHIROPRACTIC, PLLC WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT OF AUTHORIZATION TO BE PAID DIRECTLY TO HEARTLAND FAMILY CHIROPRACTIC WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. HOWEVER I CLEARLY UNDERSTAND AND AGREE THAT **I AM PERSONALLY RESPONSIBLE FOR PAYMENT AND ANY COLLECTION AND/OR ATTORNEY FEES ASSOCIATED WITH MY ACCOUNT**.

______________________________ ______________

PATIENT/ GUARDIAN SIGNATURE **DATE**

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ____________________ **Date** ____________________

1. Describe your symptoms ____________________

____

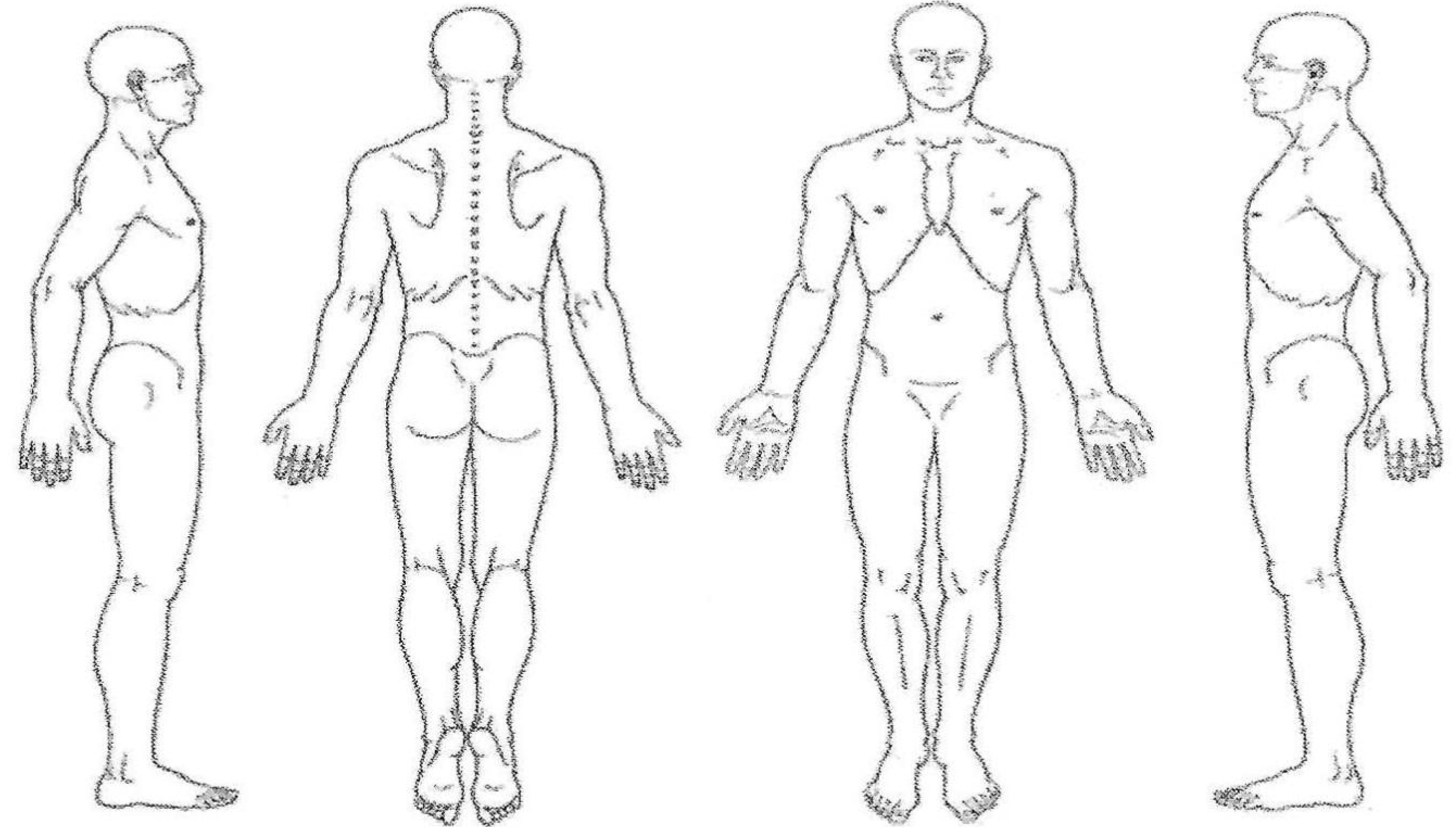
a. When did your symptoms start? ____________________

b. How did your symptoms begin? ____________________

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. What treatment did you receive and when? ____________________

b. What tests have you had for your symptoms and when were they performed?

① Xrays date: __________ ③ CT Scan date: __________
② MRI date: __________ ④ Other date: __________

9. Have you had similar symptoms in the past?

① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

10. What is your occupation?

① Professional/Executive ② White Collar/Secretarial ③ Tradesperson ④ Laborer ⑤ Homemaker ⑥ FT Student ⑦ Retired ⑧ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

Patient Signature ____________________ **Date** ____________________

HEARTLAND FAMILY CHIROPRACTIC, PLLC

1. **What was the mechanism of injury or condition? (Check all that apply)**

	Of unknown origin		After over-arching or reaching
	After a fall		After preforming household chores
	After a long drive		After performing yard work
	After a poor night's sleep		After sitting in one place too long
	After a slip		Associated with prolonged or chronic illness
	After lifting an object		Other:

2. **Activity of daily living most affected? (Check all that apply)**

	Employment		Social Life
	Homemaking		Standing
	Lifting		Traveling and/ or Driving
	Personal care (washing, dressing, etc.)		Walking
	Sitting		Other:
	Sleeping		

3. **What do you have difficulty performing due to this specific complaint? (Check all that apply)**

	Bending over		Making love
	Caring for family		Lying down
	Climbing Stairs		Reaching overhead
	Concentrating		Rising out of chair for bed
	Dressing self		Showering or bathing
	Driving car		Sitting
	Exercising		Standing
	Getting in/ out of car		Staying asleep
	Getting to sleep		Using a computer
	Grocery shopping		Walking
	Preforming household chores		Participating in yard work
	Lifting object		Other:
	Looking over shoulder		

_______________________________ Signature

_______________________________ Date

Heartland Family Chiropractic, PLLC

PATIENT CONSENT

FOR USE AND/ OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_______________________________, hereby states that by signing this Consent, I acknowledge and agree as follows.

1. **Heartland Family Chiropractic LLC (HFC)** Privacy Notice has been made available to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosure of my protected health information (PHI) necessary for **HFC** to provide treatment and to carry out other healthcare operations. **HFC** explained to me that the privacy Notice will be available to me in the future at my request. **HFC** has further explained my Privacy Notice carefully prior to my signing this Consent.
2. **HFC** reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law. Revisions of Privacy Notice will be made available to me.
3. I understand that, and consent to, the following appointment reminders that will be used by **HFC**: a.) telephone calls with detailed messages left on answering machine or with individuals that answer the phone, and b.) appointment reminder postcards.
4. I understand that, and consent to, the following policy observed by **HFC**: sign in sheets are located in a position where staff can readily see who is seeking care in the office: this information may be seen by, and is accessible to, other persons who are in the office.
5. I understand that, and consent to, the following policy observed by **HFC:** spinal manipulation and cervical tractioning are performed in an open adjustment setting: therefore, adjustments may incidentally be seen and conversations may be overheard in this situation by other persons who are in the office.
6. **HFC** may use and/or disclose my PHI in order for **HFC** to treat me and collect payment for that treatment, and as necessary for **HFC** to conduct its specific health care operations.
7. I understand that I have a right to request that **HFC** restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, **HFC** is not required to agree to any restrictions that I have requested. If **HFC** agrees to a requested restriction, then the restriction is binding on **HFC**.
8. I understand that this consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that **HFC** has already taken action in reliance on the consent.
9. I understand that if I revoke this consent at any time, **HFC** has the right to refuse to treat me.
10. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then **HFC** will not treat me.

___ I understand, **and consent**.

___ I understand, **but do not consent.**

I have read and understand the forgoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_______________________________ _______________________________

Patient/ Guardian Signature Date

_______________________________ _______________________________

Witness Date

Heartland Family Chiropractic, PLLC
1606 N. Dixie Hwy Ste. 111
Elizabethtown, KY 42701
Phone 270-234-8880

INFORMED CONSENT

Kentucky State Law requires health care providers to obtain your **INFORMED CONSENT** prior to examination and treatment. The purpose of this form is to inform you, not to alarm you. What you are being asked to sign is a confirmation that you have been informed of the following:

Examinations & X-rays: This office uses highly sensitive x-ray film, intensifying screens, and filters that provide high quality x-rays with the lowest possible x-ray exposure. The only noteworthy risk with taking x-rays deals with pregnancy. *If there is any possibility that you are pregnant, inform us prior to any x-ray examination.* If there is no possibility of this condition, the inherent risks are so rare that we have no available statistics to quantify their probability.

PLEASE CIRCLE ONE AND INITIAL: ***I AM / I AM NOT pregnant at this time/ Does Not Apply*** **Initial: __________**

Chiropractic Adjustment/ Chiropractic Manipulative Therapy (CMT): The doctor will use his hands or a mechanical device upon your body in such a way as to move your joints in various directions. This procedure may cause an audible "pop" or "click" to be heard coming from your joints, which is not cause for alarm. **There are some material risks involved in doing these procedures and they are as follows:**

- **Pain:** Chiropractic Treatments may result in a temporary increase in soreness in the area receiving treatment.
- **Rib Fractures:** Fractures caused by chiropractic treatments are rare. They occur most frequently in patients with osteoporosis or weakened bone. Evidence of osteoporosis can be noted on your x-rays, and if detected, the most appropriate, gentle treatments are used, minimizing the possibility of fractures to the ribs.
- **Disc Injury:** Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disc problems (1). Occasionally, chiropractic treatment may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable, but estimates place the risk of serious injury at *about 1 serious complication per 100 million low back manipulations(2).*
- **Vertebral Artery Dissection (VAD)/ Stroke:** The overall incidence of vertebral artery dissection leading to stroke in the general population is about *2 per 1000 people* (3). Although chiropractic adjustment/manipulation has been implicated as a possible cause of stroke, this possibility is extremely rare. The best available data suggests that stroke secondary to chiropractic adjustment/ may occur *1 per 10,000 patients* (5). The risk of serious complications or death from spine surgeries of the neck is *11.25 per 1000 patients* (5). As you can see, the risk of stroke from chiropractic treatment is much lower than other common medical treatments. Even though the risk is small, we have implemented procedures and tests that will likely reduce the potential for stroke even more.
- This list of side-effects is not exhaustive and there could be other negative side-effects of various treatments rendered in this office.

Initial: ______

I understand the risks and possible negative side effects of Chiropractic Care and other therapeutic modalities and treatments at Heartland Family Chiropractic that are involved in my treatment, and I have had the chance to ask questions of the doctor and staff regarding these procedures and make an informed decision in the treatment of my condition(s). By initialing these sections and signing this statement I authorize Dr. Fulkerson and all members of the Heartland Family Chiropractic staff to treat me using the methods designed by Dr. Fulkerson.

Initial: ______

Chiropractic is a second largest system of health care delivery. As with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this office. We will always give you our best care, and if your results are not acceptable, we will refer you to another health care provider who we feel will assist your situation.

PATIENT SIGNATURE: ______________________________ **DATE: ________________**

Heartland Family Chiropractic, PLLC
Privacy Notice

Heartland Family Chiropractic (HFC) is committed to maintain the privacy of your protected health information ("PHI"), which includes information about your health condition, care, and treatment you receive in this office. The creation of a record detailing the care and service you receive helps this office to provide you with quality health care. This Notice details how your PHI May be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

CONSENT- HFC may use and/or disclose your PHI provided that it first obtains a valid consent signed by you. The Consent will allow the **HFC** to use and/ or disclose your PHI for the purpose of:

a. Treatment: In order to provide you with the health care you require, **HFC** will provide you PHI to those health care professionals, whether on **HFC** staff or not, directly involved in your care so that they may understand your health condition and needs.
b. Payment: In order to get paid for services provided to you, **HFC** will provide your PHI, directly or through a billing service, to appropriate third party payers or collection agencies, pursuant to their billing and payment requirements. **HFC** may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.
c. Health Care Operations: In order for **HFC** to operate in accordance with applicable law and insurance requirements and in order for **HFC** to continue to provide quality and efficient care, it may be necessary for **HFC**, to compile, use and/ or disclose you PHI.

NO CONSENT REQUIRED- HFC may use and /or disclose you PHI without a written Consent from you, in the following instances:

a. De-identified information: Information that does not identify you, and even without your name, cannot be used to identify you.
b. Business Associate: To a business associate if **HFC** obtains satisfactory written assurance, in accordance with applicable law that the business such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.
c. Personal Representative: To a person, who, under applicable law, has the authority to represent you in making decisions related to your healthcare.
d. Emergency Situations:
   i. For the purpose of obtaining or rendering emergency treatment to you provided that **HFC** attempts to obtain your Consent as soon as possible; or
   ii. To a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
e. Communication Barriers: If, due to substantial communication barriers or inability to communicate, **HFC** has been unable to obtain your Consent and **HFC** determines, in the exercise of its professional judgment, which you Consent to receive treatment is clearly inferred for the circumstances.
f. Public Health Activities: Such activities include, for example, information collected by a public health authority, as authorized by lay, to prevent or control disease.
g. Abuse, Neglect, or Domestic Violence: To a government authority if **HFC** is required by law to make such Disclosure. If **HFC** is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.
h. Health Oversight Activity: Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.
i. Judicial and Administrative Proceeding: For example, **HFC** may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
j. Law Enforcement Purposes: In certain instances, you PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, **HFC** may disclose your PHI if **HFC** believes that your death was the result of criminal conduct.
k. Coroner or Medical Examiner: **HFC** may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining you cause of death.
l. Organ, Eye, or Tissue Donation: If you are an organ donor, **HFC** may disclose your PHI to the entity to whom you have agreed to donate you organs.
m. Research: If **HFC** is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.
n. Avert a Threat to Health or Safety: **HFC** may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
o. Specialized Government Functions: This refers to disclosure of PHI that relate primarily to military and Veteran activity.
p. Workers' Compensation: If you are involved in a Workers Compensation claim, **HFC** may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.
q. National Security and Intelligence Activities: **HFC** may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.
r. Military and Veterans: If you are a member of the armed forces, **HFC** may disclose your PHI as required by the military command authorities.

Appointment reminders- HFC may, from time to time, contact you to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by HFC: a) Calling your home and leaving a message on your answering machine or with the individual answering the phone; b) mailing a postcard to the address provided by you.

SIGN-IN SHEETS-HFC maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Sign-in sheets are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within **HFC's** office. This information may be seen by, and is accessible to, others who are seeking care or services in HFC's office.

OPEN ADJUSTMENTS-HFC uses an open adjustment setting to perform spinal manipulation and cervical tractioning. Adjustment, may incidentally, be seen and conversations may be overheard in this situation by other persons who are in the office.

Family/friends- HFC may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. **HFC** may use of disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following condition will apply: If you are present at or prior to the use or disclosure of your HPI, **HFC** may use or disclose your PHI if you agree, or if HFC can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

a. If you are not present, **HFC** will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION- Uses and/or disclosure, other than those described above, will be make only with your written Authorization.

YOUR RIGHTS- You have the right to:

a. Revoke any Authorization and/ or Consent, in writing, at any time. To request a revocation, you must submit a written request to **HFC's** Privacy Officer.
b. Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, **HFC** is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to **HFC's** Privacy Officer. In your written request, you must inform HFC of what information you want to limit, whether you want to limit **HFC's** use or disclosure, or both, and to whom you want the limits to apply, If **HFC** agrees to your request, **HFC** will comply with your request unless the information is needed in order to provide you with emergency treatment.
c. Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to **HFC's** Privacy Officer. **HFC** will accommodate all reasonable requests.
d. Inspect and copy your PHI as provided by law. To obtain a copy of you PHI, you must submit a written request to **HFC's** Privacy Officer. The first request will be free, but **HFC** may charge you for the cost of providing additional lists. HFC will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred. In certain situations that are defined by law, **HFC** may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.
e. Amend your PHI as provided by law. To request an amendment, you must submit a written request to **HFC**'s Privacy Officer, You must provide a reason that supports your request. **HFC** may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by **HFC** (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by **HFC**, of the information is not part of the information you would be permitted in to inspected and copy, and/or if the information is accurate and complete. If you disagree with **HFC's** denial, you will have the right to submit a written statement of disagreement.
f. Receive an accounting of disclosure of you PHI as provided by law. To request an accounting, you must submit a written request to **HFC's** Privacy Officer. The request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. The first list you request within a twelve (12) month period will be free, but **HFC** may charge you for the cost of providing additional lists. **HFC** will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.
g. Receive a paper copy of this Privacy Notice from **HFC** upon request to **HFC's** Privacy Officer.
h. Complain to **HFC** or to the Secretary of HHS if you believe your Privacy rights have been violated. To file a complaint with **HFC**, you must contact **HFC's** Privacy Officer. All complaints must be in writing.
   i. To obtain more information on, or have your questions about your rights answered, you may contact **HFC's** Privacy Officer at (270)234-8880.

PRACTICE'S REQUIREMENTS- HFC:

a. Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing **HFC's** legal duties and privacy practices with respect to your PHI.
b. Is Required by State Law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under Federal Law.
c. Is required to abide by the terms of this Privacy Notice.
d. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice effective for all of your PHI that it maintains.
e. Will distribute any revised Privacy Notice to you prior to implementation.
f. Will not retaliate against you for filing a complaint.

EFFECTIVE DATE- This Privacy Notice is in effect as of April 14, 2003.