Fink Family Chiropractic Health Intake Form
Please Fill Out All 3 Pages.

Patient Name: _____ Date: ____/____/_____

Address: _____ City: _____ State: _____ Zip: _____

Gender: ( )Male ( )Female SSN: - - Home Phone:( ) -_____

Work Phone:( ) - Birth Date: / / Spouse Name: _____

( )Single ( )Married ( )Divorced ( )Widowed ( )Separated ( )Minor

Primary Insurance Carrier(Person named on Insurance card):_____Primary's birth date:_____

Email Address _____.

Work Name & Address: _____

Occupation: _____

Whom Can We Thank For Referring You To Us?_____

Emergency Contact Name/Phone Number: _____ ( ) -_____

Name Of Person/s Responsible For This Account: _____

Auto Accident Insurance Information (IF APPLICABLE) :

Insurance Company Name/Phone #: _____ ( ) -
_____

Address: _____

Claim Adjuster Name/Phone #: _____ ( ) -
_____

Policy/Group #: _____ Claim #: _____

Fax Phone Number: ( ) -_____

What Is The Reason For Your Visit Today?_____

When Did The Symptoms First Appear?_____

Is Your Condition Getting: ( )Worse ( )Better ( )Staying The Same

Where Specifically Is/Are Your Pain/Problem Areas Located?
Which Activities Are Difficult To Perform? ( )Sitting ( )Standing ( )Walking ( )Bending
( )Twisting At The Waist ( )Lying Down ( )Other (describe) _____
How Would You Describe Your Pain? ( )Sharp ( )Dull ( )Throbbing ( )Aching ( )Shooting
( )Burning ( )Tingling ( )Crampy ( )Stiff ( )Swelling ( )Other _____

Is Your Pain: ( )Constant ( )Frequent ( )Intermittent Worse In The: ( )Morning ( )Evening
Have you ever been treated for this condition before? ( ) Yes ( ) No

If Yes, Please Indicate What Type Of Treatment You Have Had For This Condition:
( )Chiropractic ( )Acupuncture ( )Physical Therapy ( )Medical ( )Surgical ( )Other:

Please Rate The Severity Of Your Pain From Zero (no pain) to Ten (worst pain you have ever felt in your life!)

0 1 2 3 4 5 6 7 8 9 10

Do You Have Any Allergies? ( )No ( )Yes If Yes, To What?

Are You Pregnant? ( )No ( )Yes ( )Not Sure If Yes, How Many Months Along?

Please List Any Surgeries And Approx. Date They Occurred:

_____

_____

Are You Currently Taking Any Medications? ( )No ( )Yes If Yes, What Kind And For What?
Is Your Activity Level: ( )Light ( )Moderate ( )Intense Do You Smoke? ( )No ( )Yes
Do You Drink Caffeinated Beverages? ( )No ( )Yes If Yes, How Many Per Day?

Have you had any of the following:

Unexplained weightloss Y N
Pain that wakes you at night Y N
Severe headaches(worst headache ever) Y N
Loss of bowel or bladder control Y N
Unexplained fever or night sweats Y N

Please Indicate Which Health Condition Applies To You Either (P) In The Past or (N) Now By Circling Either (P) Or (N), Or Circle Both To Indicate A Problem From The Past That Is Continuing/Chronic.

P / N Neck Pain	P / N Upper Back Pain	P / N Mid Back Pain
P / N Low Back Pain	P / N Sacroiliac Pain	P / N Shoulder Pain
P / N Arm Pain	P / N Wrist/Hand Pain	P / N Upper Leg/Hip Pain
P / N Lower Leg/Knee Pain	P / N Ankle/Foot Pain	P / N Headaches
P / N Dizziness	P / N Tinnitus (ringing ears)	P / N Fainting
P / N Swelling/Stiff Joints	P / N Visual Disturbances	P / N Convulsions
P / N Stroke	P / N Heart Attack	P / N Cancer
P / N Diabetes	P / N Depression	P / N High Blood Pressure
P / N Excessive Thirst	P / N Frequent Urination	P / N Irritable Colon
P / N HIV/AIDS	P / N Asthma	P / N Arthritis
P / N Chest Pains	P / N Abnormal Wt. Gain/Loss	P / N Irregular Menstrual Symptoms
P / N Loss Of Bladder Cont.	P / N Kidney Stones	P / N Loss Of Appetite

Please Briefly List Any Other Health Care Concerns Not Mentioned In This Questionnaire That You Feel May Have Any Bearing On The Health Care You Will Receive At Fink Family Chiropractic:

I Certify that I have read and understand all information contained in this questionnaire and have answered the questions honestly and truthfully to the best of my knowledge. I further understand that providing false or misleading information may lead to mis-diagnosis and jeopardize my health. I also understand that I am ultimately responsible for fees incurred at Fink Family Chiropractic regardless of insurance coverage.

CANCELLATION / NO-SHOW POLICY:

I certify that I am aware of and agree to the policy of Fink Family Chiropractic that if I either do not show up for my appointment or, I cancel the appointment without the required 24 hour notice and fail to re-schedule the appointment, I will be billed for the office call in full. In the case of prepaid visits, the visit will be deducted from my account in full.

I also authorize Fink Family Chiropractic/Dr. Mike Fink, D.C. to release any pertinent health care information to any third parties such as my insurance company or any other health care providers I have been referred to by Dr. Mike Fink, D.C./Fink Family Chiropractic for the purpose of continuity of care provided to me by Dr. Mike Fink, D.C./Fink Family Chiropractic and other health care providers I have been referred to by Dr. Mike Fink, D.C./Fink Family Chiropractic and/or to expedite insurance payment of any bills incurred at Fink Family Chiropractic.

I also realize and acknowledge that Dr. Mike Fink, D.C./Fink Family Chiropractic reserve the right to either accept or decline me as a patient at Fink Family Chiropractic.

X_____ Date:

(Signature of Patient or Guardian If Patient Is a Minor)

How Fink Family Chiropractic(FFC)/Dr. Michael Fink, D.C./Staff & Associate D.C.'s In Accordance With HIPAA Guidelines, Protects Your Personal Health Information (PHI).

Treatment:
Fink Family Chiropractic/Dr. Fink & staff may use your Personal Health Information (PHI) to provide you with chiropractic Treatment or other health-related services. FFC/Dr. Fink may use your PHI to coordinate care with other health care providers/insurance carriers/third parties participating in your care. FFC/Dr. Fink may provide PHI to family members or persons you have indicated that are involved in your care, PHI that is directly relevant to their involvement in your care or payment for your care.

Payment:
FFC/Dr. Fink & staff may use and disclose your PHI in order to receive payment for the treatment you receive at FFC from Dr. Fink or an approved associate/practice relief doctor.

Health Care Operations:
FFC/Dr. Fink & staff may use and disclose PHI about you for our health care operations, which are activities necessary to operate Fink Family Chiropractic to ensure that all of our patients receive quality care.

Health Care Associates:
There are some services provided by us through contracts with other health care providers. When these services are contracted for, we may disclose your PHI to our Associates so that they can perform the job we have asked them to do and bill you or your third-party payor for services rendered. To protect you and your PHI, we require these associates (X-Ray/MRI/CAT Scan facilities, Physical Therapy Clinics, Other D.C.'s) to appropriately safeguard your PHI in accordance with HIPAA guidelines.

Special Situations Involving Public Health Or Legal Requirements:

- If required by law.
- To the MBCE (Minnesota Board of Chiropractic Examiners), members, inspectors or agents thereof.
- For the purpose of reporting, or informing authorities of possible victims of abuse, neglect or domestic violence and for Public Health activities such as communicable disease reporting, or informing authorities of possible victims of abuse, neglect or domestic violence.
- For government health care oversight activities.
- For law enforcement purposes, in response to a valid court order or warrant, or as specifically required or permitted by law, including disclosures to an inspector or investigator whose duty is to enforce the laws relating to chiropractic and who is engaged in a specific investigation involving a designated person or chiropractic service, or for reporting suspected crimes such as child abuse.
- To avoid a serious threat to your health or safety, or the health and safety of the public or another person.
- To medical examiners, funeral directors, or organ procurement organizations, in regard to a deceased person.
- To a correctional/mental health/long term care/chemical dependency rehabilitation or other facility engaged in the administration of your health care when necessary for your health or the health and safety of others, if you are or become a resident of any such facility.
- For special government functions, such as disclosures to authorized federal officials for national security activities.
- As required by military command authorities if you are a member of the armed forces, or a member of a foreign military.
- To comply with state laws relating to worker's compensation and similar programs for work related injuries or illnesses.

Uses And Disclosures You Specifically Authorize:

Your Rights

ACCESS: Each person over the age of 18 has the right to review and obtain a copy of his or her PHI contained in a designated record set, with limited exceptions. The designated record set usually will include treatment and billing records. Parents of minor children may also request the records of their minor children. We require you to send a written request to Privacy Officer, Fink Family Chiropractic 120 E. Main St Sidney, MT 59270. If you request copies, we may charge you a fee to cover the costs of copying, mailing and other supplies. We may deny your request to review and copy in certain limited circumstances. If we deny your request, you may be entitled to a review of that denial.

Some state laws allow minors to keep some records confidential from parents or guardians in certain cases. If a minor chooses to use his or her parents' insurance or payment information, we cannot assure that the records will be kept confidential. Minors must notify FFC/Dr. Fink in writing in situations where the minor believes the information should be kept confidential so that FFC/Dr. Fink can make a determination about whether the information must be shared with a parent or guardian. Dr. Fink/Associate D.C.'s are permitted to inform the parent of guardian if in the judgment of the doctor, failure to inform the parent or guardian would seriously jeopardize the health of the minor patient.

Amendment: If you feel that your PHI is incorrect or incomplete, you have the right to request that we amend it. We require you to send a written request to Privacy Officer, Fink Family Chiropractic 120 E. Main St Sidney, MT 59270.

You must include a reason to support your request. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be included in your records.

Accounting of Disclosures: You have the right to receive a list of disclosures we have made of your PHI. This right does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. We require you to send a written request to Privacy Officer, Fink Family Chiropractic 120 E. Main St Sidney, MT 59270.

Your request must specify a time period, but may not be longer than six years from the date of this request, and must not go back further than April 14, 2003.

Restrictions Requests: You have the right to request that we place restrictions on our use or disclosure of your PHI for treatment, payment and health care operations. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency). We require you to send a written request to Privacy Officer, Fink Family Chiropractic 120 E. Main St Sidney, MT 59270.

Confidential Communication: You have the right to request that we communicate with you in confidence about your PHI by alternative means or to an alternative location. For example, you may ask that we contact you only at work or by mail. You must specify how or where you wish to be contacted. We will accommodate all reasonable requests. We require you to send a written request to Privacy Officer, Fink Family Chiropractic 120 E. Main St Sidney, MT 59270.

Others Acting on Your Behalf: These rights may also be exercised by someone who has the legal right to act on your behalf.

Copy of this Notice: You are entitled to receive a printed (paper) copy of this notice at any time. We require you to send a written request to Privacy Officer, Fink Family Chiropractic 120 E. Main St Sidney, MT 59270.

For More Information or to Report a Problem: Contact HIPAA Privacy Officer Fink Family Chiropractic 120 E. Main St Sidney, MT 59270 (406)433-2225.

You may also submit a written complaint to the U.S. Department of Health and Human Services at the address below:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint.

Patient Signature: _____ Date: _____