ENTERPRISE CHIROPRACTIC CLINIC
Doctor Albert Noble

Beinvenidos a nuestra clinica

Initial Visit Form

GENERAL INFORMATION (all clients fill out)

Informacion del Paciente:

Apellido nombre secundo nombre	Fecha de hoy
Domicililo (No PO Box)	Como sabes de nosotros
Ciudad estado codigo postal	Numero de securo social numero de licensia
Telefono de casa	sexo estate matrimonial fecha de nacimiento H M Soltera casado Div. viuda.
Telefono de trabajo/ cellular	Nombre de contacto de emergencia
Correo electronico	Numero de telefono de emergencia

Informacion de la asecuranca:

Nombre del asugurado fecha de nacimiento	Fecha que te lastimaste (fecha del accidente)
Tu relacion con el asugurado	Poliza # Claim # / ID #
Nombre de la compania aseguradora	Que tipo de lastimadura /accidente (escoje uno) trabajo accidente vehicular otro (explique por favor):
Reclamacion al seguro/direccion pare la factura	
Ciudad Estado Zona postal	

Historial Medico (all clients fill out)

- Cuando fue tu ultimo examen fisico? _____Quien te lo hizo ? _____
  no me acuerdo cuendo fue mi ultimo examen fisico
- Has tenido un accidente previo/trauma/caidas? **Si/ No/ no me acuerdo** fecha: _____
  Esta problema resulto? **SI/ No** ***(si circulas si , no conteste la #3)***
  Si es No, tienes los o similares condiciones? **SI/ No/ no me acuerdo**
  Si contesta **SI,** esplique alguna differencia de intensidad/ frequencia/ duracion del dolor que sientes actualmente :_____

- Explica cualquier hospitalacion previa: _____ no me aguerdo de hospitalacion previa

- Has tenido sirugias antes? **Si/ No/ no me acuerdo**
  Que tipo(s) y la fecha(s)?
  _____

- Te has lastimado en trabajo previamente? **SI/ No/ no me acuerdo** fecha: _____
  Esta esto resulto? **SI/ No** ***(si circula si, ve a la pagina 2: Jefe queja/dolencia)***
  Si contesta No, tienes el mismo o similar condicion? **SI/ No/ no me acuerdo**
  Si contesta **SI**, explique alguna diferencia de intensidad/frequencia/duracion del dolor que sientes actualmente:_____
  Name: _____Date: _____Claim Number: _____

CHIEF COMPLAINT (all clients fill out)

Notas: Rango 1-10 key: **1-4 = suave, incomodo; 5-7 = angustiante; 8-10 = intenso, insoportable**

- Marca todos lo que aplice. Tu experimentas:

Dolor de cabeza- a donde: dolor cara(784.0) toda la cabeza frente atras de cabeza ojos
temple lado derecho lado izquierdo
otros:_____
intensidad: (de 1-10):_____ Cometarios: _____

Dolor cuello- a donde: brota hacia arriba en espalda lado derecho brota hacia arriba en espalda lado isquierdo
arriba/abajo mas de lado derecha mas de lado izquierdo irradiar en la cabeza (723.2) dolor cuello(847.0) otros:_____
Intensidad: (de 1-10):_____ Comentarios: _____

Dolor hombro - adonde: lado izquierdo lado derecho los dos lados
intensida: (de 1-10):_____ Comentarios: _____

Dolor espalda media- a donde: toda la espalda media mas el lado derecho mas el lado izquierda

brotar al rededor del pecho radiating a la cabeza(724.4) irradiar a los brazos/piernas (724.4) otros:_____ Intesidad:(de1-10):_____ Comentarios:_____

Dolor espalda baja-:a donde toda la espalda baja mas al lado derecho mas al lado izquierdo
se dispara al brazos/piernas otros: _____
Intensidad: (de 1-10):_____Comentarios: _____

Dolor Cadera/pelvis -: a donde caderas Pelvico lado izquierda lado derecho dos lados
Intesidad: (de 1-10):_____ Comentarios: _____

Dolor brazos/piernas-: a donde brazo izquierdo brazos derecho dos brazos pierna izquierda pierna derecha dos piernas
Intensidad: (de 1-10):_____Comentarios: _____

Dolor en el Tobillo- a donde: tobillo izquierdo tobillo derecho dos tobillos
Intensidad: (de 1-10):_____Comentarios: _____

Otro:_____- Donde espesificamente: _____
Intensidad: (de 1-10):_____Comentarios: _____

Name: _____Date: _____Claim Number: _____

- Lista cualquier medicamento que estes tomando y esplica cualquier efecto segundario: *No aplica* Insulina Cortisona patillas pare nervios Antidepresibos Shoe lifts
medicamento para presion alta Vitaminas/suplementos
Aspirina- que tan sequido? _____ pastillas para dolor/relajante de musculo
Algun efectos secundarios :

_____

C.: sientes a dormecidos o cosquillero piernas /pies pierdes tu balance
sientes a dormecidos o cosquillero brazos *no aplica*

- Possible sintomas /dolor de mandivula. Marca los que aplican:

dolor oido, dolor, pica, dolor afilado sonar en el oido mareo problemas de los dientes cara entumecida rechinas lo dientes en la noche dolor en articulacionde mandibula o clic sientes tu oido lleno, tapado
otro-explicar por favor:
_____
no aplica

E. sintoma relacionado con posible cerebro and brainstem. marque todos que a aplica:

problemas con/largo o corto term memory problemas para concentrarte agravar/ molestar con ruido anciedad depresion irritable problemas para dormir fatiga problemas sexuales
cambio en gusto o oler otros- por favor explicar:
_____ *no aplica*

- Cuanto tiempo/regularmente tienes o sientes dolor?

todo el tiempo durante el dia durante la noche mas de 6 horas menos de una hora
in intervals-how long each time?
_____
otro- por favor explique:
_____

- Que hace dolor mejorar ?

aspirina movimiento- a que direccion:
_____
caliente hielo masaje relajante de musculo descansar
expansion descansar en cama elevacion *nada*
otro-por favor explique:
_____

- Describi cualquier actividad que haga tus simtomas peor:

_____
_____

- Cueando y como empeso el dolor :

_____

- J. Describi cualgier informacion adicional sobre tu condicion: _____ __

  - El accidente / lastimadura en peso el dolor hace mas de dos semanas? **Si / No**
    Si es si , por favor explique por que no vino antes de dos semana: _____
    _____
    _____

Name: _____**Date:** _____**Claim Number:** _____

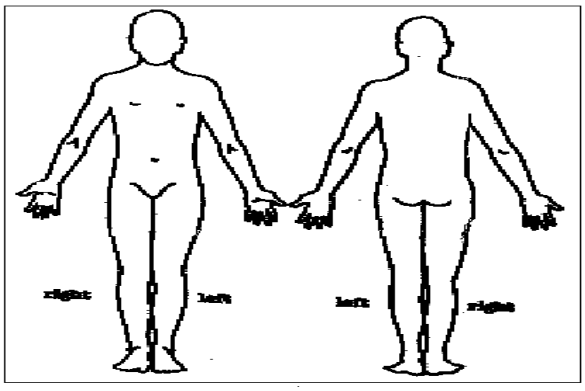
Ensene las areas que siente dolor / siente sensaciones diferente o nousual

Marca la area en este cuerpo donde tu sientes la sensacion describir. Usa los simbolos apropiados. marca la area de radiacion (pain that spreads). Inculle todas las areas afectadas.

entumecido	ardor	Agujas	dolor	doler	apunalar
- - - - - - - -	# # # # # #	0 0 0 0 0 0 0	x x x x x x	* * * * * *	/ / / / / / / /
- - - - - - - -	# # # # # #	0 0 0 0 0 0 0	x x x x x x	* * * * * *	/ / / / / / / /
- - - - - - - -	# # # # # #	0 0 0 0 0 0 0	x x x x x x	* * * * * *	/ / / / / / / /

Por favor marque del cero a 10 la intensidad del dolor que siente con su condicion. 10 peor dolor que ayas sentido con esta condicion

Pain Chart



Dolor cuello-espalda-brazos
On a scale of zero to 10, I rate my
Discomfort as follows
(_____)

•
10
No dolor
dolor severo

Dolor espalda media
On a scale of zero to 10, I rate my
Discomfort as follows
(_____)

0
10
No dolor
dolor severo

Dolor

Espalda baja y piernas

On a scale of zero to 10, I rate my
Discomfort as follows
(_____)

0

10

Nodolor

dolor severo

Fecha:_____ Firma: _**X**_____

SYSTEMS REVIEW

NAME:_____ **DATE:**_____ **CLAIM NUMBER:** _____

Por favor revise las siquientes condiciones. Si as tenido alguna condicion en le pasado marque en la columna 1. Si tienes la condicion ahora marque columna 2.

pasado	ahora		GENERAL
		780.6	calen
		780.9	refriedo
		780.8	Sudor noche
		780.2	desmayarse
		780.4	mareo
		780.3	Convulsions
		780.52	Perdida de sueno
		780.7	cansancio
		799.2	nerviosismo
		783	Perdida de peso
		782	dolor/miembro entumecido
		995.3	alergia
		786.09	resoplido
		729.2	Neuralgia

pasado	ahora		OJOS,OIDOS,NARIZ,GARGANTA
		368.9	Pobre vision
		378.9	Ojos cruzados

pasado	ahora		GASTRO-INTESTINAL
		783	Poco apetito
		536.8	Pobre digestion
		994.2	Hambre excesiva
		787.3	eructar o Gas
		787	Nausea
		787	Vomito
		578	Vomitanto sangre
		536.8	Dolor sobre estomago
		564	estrenido
		558.9	Diarrea
		789	Problema del Colon
			sangre en Stool
		455.6	Hemorroides/Piles
		785.1	problemas del higado
		782.4	Piel amarilla
		575.98	problemas del vejiga

pasado	ahora		SOLAMENTE MUJERES
		786.2	mentruasiones dolorosas

		379.91	Dolor en ojos
		689.9	sordera
		388.7	Dolor de oidos
		388.3	Ruido en oidos
		388.6	oido Discharges
		478.1	Obstruccion nasal
		784.7	Sangrado nariz

		462	Garganta adolorida
		784.49	**Ronco**
		477.9	Fiebre heno
		793.9	Asma
		460	Refriado frecuente
		240.9	Engrosamiento tiroides
		463	amigdalitis
		686.9	Problema senunitis

pasado	**ahora**		**CARDIO-VASCULAR**
		783	Corazon rapido
		427.89	Corazon despacio
		401.9	Presion alta
		458.9	Presion baja
		786.51	Dolor sobre corazon
		438	Problema del corazon
		719.07	Hinchazon en tobillo
		459.9	Mala circulacion
			Vena varicosa
		436	Derrame cerebral

pasado	**ahora**		**GENITALES-URNIARY**
		788.3	Orinar frecuentemente
		788.1	Dolor al orinar
		599.7	Sangre en orin
		592	Infeccion en rinon
		788.3	Mojas la cama
		788.1	No control orinar
		601.9	Problema de prostata

		626.2	Flujo excesivo
		626.4	Ciclos Irregulares
		627.2	calores
		625.3	calambre/dolor de espalda
		634.6	aborto
		623.5	Flujo blanco
			embarazo

ultimo Papanicol fecha:_____
Fecha que comenzo tu ultimo periodo:_____

pasado	**ahora**		**MUSCULO O JOINTS**
			debil
			Twitching
		719	hinchado Joints
		781	temblor
		729.5	Problema pies
		724.79	Hueso tail dolorosa
		724.5	Dolor entre hombro
		553.9	Hernia
		737.3	Columna vertebral Curvature

pasado	**ahora**		**PIEL O ALERGIAS**
		368.9	erupcion piel
		698.9	picason
		287.8	Moretones facilmente
		701.1	seca
			furunculos
		782	Piel sencible
		708.9	urticaria/Alergia
		692.9	Eczema

SYSTEMS REVIEW

NAME:_____ **DATE:**_____ **CLAIM NUMBER:**

Por favor revisa as siquientes lista de condiciones. Si as tenido alguna condicion en el pasado marca la columna 1. Si tienes alguna condicion ahora marca la
columna 2.

pasado	ahora	N/A	HABITOS	pasado	ahora		RESPIRATO
			Fumas_____Paquete(s)/dia			786.2	Tos Chron
			Alcohol_____tomas(s)/dia			766.3	escupir s
			Café_____taza(s)/dia			933.1	escupir f
			No ejercisio			786.5	Dolor en
			Moderado ejercisio			786.09	Dificulta
			Diario ejercisio				
			Comes bajo en sal/dieta grasa				
			Tienes una dieta balanciada				
			Estresado en casa/trabajo				

HISTORIAL FAMILIAR				Diabetes	Corazon	Rinon	Cancer
Madre:	vive	fallecido	(circule uno)				
Padre:	vive	fallecido	(circule uno)				
Hermanos:			cuantos? _____				
Hermanas:			cuantos? _____				

MARGUE SI AS TENIDO ALGUNA DE ESTA ENFERMEDES:

	541	Apendicitis		285.9	**varicela**
	541	**neumonia**		**285.9**	**Anemia**
	541	Fiebre reumatica		285.9	Sarampion
	541	Polio		285.9	paperas
	541	Tuberculosis		285.9	Diabetes
	541	Tos ferina		285.9	Cancer
	429.9	Enfermeda del corazon		716.9	Artritis
	429.9	Buche,bocio		716.9	Epilepsia
	429.9	gripe		716.9	Desorden
	429.9	pleiritis		716.9	Lumbago
	429.9	Alcoholismo		716.9	Eczema
	429.9	Enfermedad venerea			

LISTA SI TIENES ALGUNA ALERGIAS:

N/A

Name: _____Date: _____Claim Number: _____

Informacion sobre accidente vehicular (MVA clients solamente)

- Fecha del accidente:_____: Numero de carros involucrados en el accidente: _____
- Auto que estabas: Año: _____ Marca: _____Modelo: _____
  Dano: menor mayor total aprox. $ _____ valor
- Eras tu el dueno del carro: **Si/ No**
- Otros auto(s): Año: _____ Make: _____ Modelo: _____
- Calle/Interseccion Nombre(s): _____
  Ciudad/Estado: _____
- fue: interseccion luz/signo de para (circule uno) no interseccion
  si fue en la luz, estaba: verde rojo amarillo felcha para doblar
  la superficie estaba: seco mojado lizo heilo gravilla otro: _____
- Que tan rapido y en que direccion iva tu carro moviendo cuando pego/pegaron? _____
- Que tan rapido y en que direction estaba el otro carro moviendo cuando te pego? _____
- Donde estabas sentado en el vehiculo?
  manejador pasajero enfrente pasajero atras izquierda/derecha/centro (circule uno)
  atras en la cama de truca manejador de motocicleta/pasajero (circule uno)
  otro-por favor esplicar : _____
- Como estaba tu cuerpo posicionado al tiempo del acidente?

mirando hacia abajo asiendo algo mas mirando al trafico viniendo
mirando al pasajero mirando a enfrente
doblar a la izquierda/derecha (cirgule uno) mirando a traffico oncoming
mirando por el espejo rear view mirando al manejador
otro-por favor explique:
_____

- En que areas de tu carro le pegaron ?
  enfrente lado de la esquina manejador esquina trasera al lado manejador lado del manejador
  enfrente esquina pasajero esquina trasera del pasajero lado pasajero
  defense delantera defense trasera trasera trailer
  collision de frente total otro: _____

- habia otro secundo impacto? **Si/ No** Si, a donde fue el impacto en tu carro? _____

- Mi cuerpo pego el volante respaldo
  paneles de al lado asiento con mi pecho/abdomen/cabeza/cara (circulo uno) tablero
  puerta atras del asiento del manejador
  pavimento
  consolar otro-por favor explique:
  _____

Name: _____Date: _____Claim Number: _____

- Las siquientes parte de mi cuerpo fueron golpiadas: cara frente nariz cuello hombro brazo mano muneca dedos pello abdomen cadera muslo rodilla shin
  otro- Por favor esplique: _____

- Descripcion adicional del acidente:
  _____
  _____
  _____

- Huvo un aviso antes del impacto?**Si/ No**
- Se desplego la bolsa de aire?**Si/ No**

- Tiene tu carro respaldor? **Si/ No**

- Como resultado del accidente estuviste: indefenso/incosciente aturdido
  no puedes mover ciertos partes del cuerpo-por favor explique que partes y porque:
  _____
  moreton o sangrar (Porfavor describer lesion):
  _____
  conmocionado pero puedo funcionar si pudo parar/fuera del carro y caminar no muy preciso sobre lo que sucedio

- Si te acuerdas haberte golpiado la cabeza? no me acuerdo de haberme golpearme la cabeza
  Si, me acuerdo de golpearme la cabeza No, me golpie la cabeza

Siquiendo el accidente:

- Estaba el personal de emergencias en la escena? **Si/ No**

- Te llevaron a el hospital cuarto/ habitacion de emergencias? **Si/ No**
  Si, nombre del hospital: _____Que areas te comprobar/trataron? _____

- Tu hiciste sequimiento con el tratamiento para tus heridas? **Si/ No**
  Si , en cual hospital? _____

- Te tomaron rayos x?**Si/ No** Si, que parte del cuerpo? _____
  Por quien? _____
  Tu reportaste el accidente con tu compania de seguro? **Si No**

- Tu tienes un abogado que te represente por este accidente ? **Si No**
  Si, por favor proporcionar los siguientes para nuestro registros:
  Nombre del abogado: _____ telefono # _____
  Direccion del abogado:
  _____
  ciudad/estado/zona postal :
  _____

Name: _____Date: _____Claim Number: _____

Consentimiento para tratar & Acuerdo financiero (*por favor leer y firmar)*

Yo comprendo completamente que Yo soy reponsable directamente/completamente por todos los cargos la clinica, contraer por servicios hechos a mi, y que este arreglo esta hecho unicamente para proteccionde clinica I en consideracion contingete de cualquier resolucion, fallo o veredicto por cual yo pueda finalmer recuperar. Yo soy la persona responsible por la factura, a pesar de cualquier resultado de reclamo/cau legal.

Yo autorizo a mi compania de seguero que hago pagos directamente a esta oficina. El doctor no se reponsable por niguna condicion medica diagnosticada pre-existente.

Nosotros llamaremos para verificar elegibilidad y benefios como cortesia a nuestros pacientes. Cor la poliza del seguro es un contrato entre el pacient y la compania de seguro, Nosotros no podem garantizar estos beneficios. Cualquier cantidad que la compania de seguro no cobra pasara hac responsabilidad de el paciente, a pesar de todo de alguna reduccion, negacion o arbitrar determinacion de honorarios habitual /acostumbrado. Nosotros aconsejamos/ asesoral nuestr pacientes que verifique su propio seguro.

En orden para tener privilegio/honor para facturar el seguro prorrogada a mi,Yo entiendo que yo ten que: reportar mi accidente ala compania de seguro de auto a la oficina de reclamos y proporcionar a compania de seguro de auto con toda la solicitud necesaria PIP (Personal Injury Protection) (personal lesi proteccion).

Yo e leido, comprendido,y estoy de acuerdo con el contrato sobre finansamiento declarado arriba.

fecha _____ **X** _____ firma de los padres, //guardian legal para pacientes menores de 18 anos

fecha _____ _____ firma del testico

Name: _____ **Date:** _____ **Claim Number:** _____

Una cita es un compromiso de ti mismo y el doctor que hizo a un lado tiempo para tratarte. Por lo ta
Nosotros pedimos/ solicitamos que nuestros pacientes nos informen por lo menos 24 horas adelantado cua
quieran cancelar o volver a programar una cita , para que nosotros podemos hacer la cita disponible para qu
lo necesite.

Nosotros reservamos el derecho de cobrar la cantidad de $25.00 por citas perdida, a esos pacientes
pierden sus citas sin notificarnos o informanos o quien cancele/ volver a programar una cita con menos de
horas de aviso. Esta cuota/honorarios no esta cubierto por seguro y necesita ser pagado por el paciente.

Para no inconvenier a los que llegan a su cita a tiempo, los que llegen tarde van a recibir cortos/reducid
tratamiento y la cuota regular del tratamiento. Para aquellos que llegen atiempo para su cita seran atendi
primero.

Tambien, nosotros no somos responsable por articulos personales perdidos/robados. Nosotros no so
responsable por los ninos o cualquier nino que pueda estar contigo durante tu visita. Nosotros no so
responsable por ninguna lesion que pueda occurrir en casa por hacer los ejercicio que el medico te dio.

Nosotros valoramos tu negocios y asegurar que nosotros estamos disponible para ti cuando nos neces
Gracias.

Yo comprendo y estoy de acuerdo con lo de arriba:

X_____
firma del paciente fecha

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & Motor Vehicle Collision General Precautions and Instructions

Yo, _____ (tu nombre), Reconosco que yo e recibido, revisado, entendi
comprendido y, estoy de acuerdo con el aviso de practicas de privacidad de Enterprise Chiropractico y
Motor Vehiculo Colision General Precaucion y Instrucciones, cual describe el ejercer politica/ poliz
procedimiento con rescoto a el uso y revelacion de cualquier de mis informacion de salud protegerla
creado recibida o mantener por la y proporcionar instrucciones para cuidado en casa.

X_____
firma del paciente fecha

Print Name _____

Uso para oficina solamente

The Practice has made a good-faith effort to obtain an acknowledgement of _____'s receipt of our Notic
Privacy Practices. In an effort to obtain it, the Practice has attempted to provide patient with a Notice of Privacy Practices in
following manner: Personalmente correo Phone Follow-up otro _____
In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons:
paciente no esta disponible paciente fisicamente no puede pacient no esta dispuesto. Firma/ fecha

ENTERPRISE CHIROPRACTIC CLINIC
Doctor Albert Noble

IRREVOCABLE DOCTOR'S LEIN AND ASSIGNEMNT OF RIGHT TO RECOVERY

Name: _____ **Date:** _____ **Claim Number:** _____

En consideracion y intercambio para que no tengas que pagar tu deuda inmediatamente y en consideracion recidiras en el futuro cuidado en o por la clinica y el doctor en de quien de quien letterhead en este document esta imprimido (hereinafter "clinica"), Yo, el lo abajo firmante, por esto asignar y trasmitir a la clinica un legal y equitable interesen cualquier y todas la causa de accion o derechos de recuperacion yo puedo haber surgido/presentarse fuera de ese cierto accidente o lesion-producir/ fabricarze acontecimiento que ocurra/sucede en o sobre_____ , a la lleno alcance de el costo y tratamiento proporcionado o va hacer proporcionado a mi por la clinica.

Yo como resultado de esto autorizo y directo a mi abogado(s) con toda confiansa, y que page directamente a la clinica la suma,cantidad que se deba a la clinica por tratamiento y otros servicio professional prestados mi las dos por la razon de el accidente y por razon de cualquier otras factures que se le dedan a la clinica y de retener tal suma desde cualguier ver,conceder y transportar a otra persona con mi caso a la clinica contra cualquier y todo lo recaudado de cualquier y todo causade accion, resolucion, fallo o veredicto cual se pueda pagar a o a traves de mi abogado, or yo mismo, como resultado de mi lesion o condicion por la cual e ver tratado por la clinica .

Si no abogado puede ser confiado con mi caso , Yo entiendo/comprendo que el seguro le pagara directamente a la clinica por todos los servicios prestados como resultado de este accidente y o cualquier otra factura que se deba.

Yo comprendo completamente que yo soy directamente y completamente responsable a la clinica por todas las facturas contraer por servicios prestados a mi y que el acuerdo esta hecho unicamente por la clinica para protection adicional y en consideracion contingente en cualquier resolucion,fallo o veredicto por que yo pueda finalmente recuperar. Yo soy personalmente responsable por mi factura, a pesar de todo i del cualquier resultado,afirmacion legal o causa.

Yo comprendo completamente que si mi abogado(s) si o no protégé los interes de la clinica, la clinica puede requerirme a mi que haga pagos en mi cuenta. La clinica tambien puede traer provocar accion contra mi abogado(s) por fallar a honrar este vinculo y irrevocable trato entre mi y la clinica

Yo ademas comprendo y estoy de acuerdo que la clinica *no es* responsable por el honorarios de mi abogado y la clinica *no* esta de acuerdo en pagar los honorarios del abogado por honor acuerdo entre yo y la clinica.

"I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY(S) TO PROTECT THE CLINIC'S AND DOCTOR'S INTEREST AT TIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHTS TO THE CLINIC. I ALSO KNOW I MAY *NOT* REVOKE THIS AGREEMENT AT ANY TIME WITHOUT PRIOR WRITTEN AUTHORIZATION FROM THE CLINIC. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT AND LEIN.

_____ **X**_____

_____

Imprimir Nombre paciente Firma del paciente Fecha

_____ _____

_____

Imprimir Nombre abogado / Firma del Abogado/ Ajustador
Fecha

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION-RECORDS

Last name:	MI:	First Name:	
Home Address:	City:	State:	Zip:
Date of Birth:	Social Security/ID Number:		

The 1996 Health Insurance Portability and Accountability Act (HIPAA) require that all health care providers comply with the patient privacy and security laws (45 CFR Parts 160, 164). Patient confidentiality and privacy/security applies to any protected health information (PHI) contained within the medical records. Federal Law now require signed and dated authorization from patients in several aspects of patient care, transmission of medical information, confidentiality, and patient rights relating to their release of medical records.

LIST PURPOSE(S) FOR WHICH THE INFORMATION IS NEEDED:

_____

AUTHORIZATION EXPIRATION. Without my express revocation, this authorization will expire 12 months from the date signed: (1) upon satisfaction of the need for disclosure; (2) on date (supplied by patient) _____; (3) under the following conditions (examples: case closure, termination of plan benefits, ECT) _____

RELEASE AUTHORIZATIONS (Patient, please initial the following section(s) that apply to you.

_____ **Initial.** Doctor/Medical Facility... I authorize release of entire set of my medical records including: intake forms, history, diagnosis, treatment, consultation, neurological/laboratory/radiologic scan or test results, disabilities, billing information, reports, correspondence, and medical records from other sources to the following doctor/facility/person:
List Name/Address: _____

_____ **Initial. Insurance-Medical Plans. I** authorize said doctor to communicate with, send updated billing, reports, and release all medical records necessary to process this claim to the following insurance companies and/ or governmental agencies listed below:
List: _____

_____ **Initial**. **Attorney**. I authorize said doctor to communicate with my retained attorney (paper, electronic, and oral). I further authorize the release of reports, all medical and treatment records, billing records photos, and other records necessary to process my claim. This authorization is valid until the case is closed or at the conclusion of litigation and said doctors bills have been fully paid.

Name of attorney: _____, Date of Injury: _____

_____ Initial. **Family/ Friend.** I authorize said doctor to communicate with the following friend/family member about my health condition and recommendations. Name of person(s): _____

_____ **Initial □ Yes, □ No: [Special Limitations for Release of Sensitive Protected Health Information.]** I specifically authorize the release of HIV/AIDS test results, sexually transmitted or communicable disease notes (such as Hepatitis or venereal diseases), drug, alcohol, or substance abuse or treatment notes, behavioral, mental health disabilities or developmental disability, (including mental retardation), abuse, neglect or domestic violence, sickle cell anemia, government research, or genetic testing information. The recipient is prohibited from redisclosing such sensitive PHI information without my authorization unless permitted by state and Federal law. List any other special restrictions that you want limited (e.g., psychiatric/psychological records):
_____

AUTHORIZATION

- I certify that this request has been made freely, voluntarily and without coercion and that the information is accurate.
- I voluntarily authorize and request that my health information (including paper, oral, and electronic interchange) be release to the above sources as set forth on this form.
- I can revoke this authorization at any time by giving my written revocation in writing to said doctor's office. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this authorization
- The disclosing health care provider/plan/may NOT condition treatment, enrollment in the health plan or eligibility for benefits on whether I sign this authorization.
- Information disclosed under this authorization may be rediclosed by the recipient and may no longer be protected by federal and state law.
- I have the right to request a list of doctors, facilities, and/or government agencies which have been sent my medical records.

_____
X_____
(Date) (Signature of Patient)

_____
_____
(Date) (Signature of person authorized by law)

REQUEST FOR MEDICAL RECORDS

PATIENT NAME: _____ DATE: _____

Patient Identification:	Social security: Date of Birth: Medical record No:

Request Records From (Name and address of Doctor/ Facility where patient's medical records are presently located):

Name:	
Address:	

SEND THE SPECIFIED AND AUTHORIZED MEDICAL RECORDS TO:

Doctor's Name:	Dr. Albert Noble D.C. Enterprise Chiropractic Clinic
Address:	10576 SE Washington St, Portland, OR, 97213
Telephone:	503-252-5320

WHAT MEDICAL RECORDS ARE AUTHORIZED TO DISCLOSE AND MAIL:

□ All Medical Records
□ X-Ray/MRI/CT reports
□ EMG, SSEP, Nerve Conduction, Laboratory tests, Diagnostic Test Report.
□ Other

_____

SPECIFIC DATES AUTHORIZED FOR RECORDS RELEASE

Medical records from (insert date) _____ to (insert date) _____

PURPOSE OF RELEASE OF INFORMATION

□ At request of above patient
□Other:

I hereby request and authorize disclosure of the above protected health information in my medical records kept at your office or facility to be photocopied, released and mailed to above doctor/facility at the indicated address for the specified dates. I understand that the Health Insurance Portability and Accountability Act (HIPAA) apply to my medical records and protected health information. I expect the holder of my medical records to mail my specified medical records as soon as reasonably possible, not to exceed 30 days if kept on-site, and 60 days if stored off-site, once this request has been received. This authorization may be revoked by me, at any time, by advising the doctor's office (privacy officer) of this revocation in writing, except to the extent a source of information has already relied on it. I have been advised that if I choose to not sign this authorization that it will not have any adverse effect on my treatment, eligibility for benefits, enrollment, or payment.

EXPIRES: This authorization is good for 12 months from the date signed for the disclosure of the information
described above.
*This authorization does not apply to any record/notes regarding HIV/AIDS, communicable disease, alcohol or drug treatment, mental health information, behavioral health care, domestic violence, genetic testing, and psychiatric or psychotherapy notes.

PATIENT NAME (Print clearly):

_____

INDIVIDUAL AUTHORIZING DISCLOSURE (Signature): _____ DATE: _____

If not signed by patient, specify basis for your authority to sign: □ Parent of minor, □ Guardian

This general and specific authorization to disclose was developed to comply with the provisions regarding disclosure of medical information under HIPAA: 45 CFR Parts 160and 164, 42 CFR part 2, 38 CFR parts 99 and 300, and State Law.

PATIENTS COPY

ENTERPRISE CHIROPRACTIC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of Our Privacy Practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of 04/15/03, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the Privacy Practices described below at any time in accordance with applicable law. Prior to making significant changes to our Privacy Practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you upon request. Any changes we make to our Privacy Practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our Privacy Practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. TREATMENT, PAYMENT, and HEALTH CARE OPERATIONS: You should be aware that during the course of our relationship with you, we will likely use and disclose health information about you for treatment, payment, and health care operations. Examples of these activities are as follows:

- Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

- Payment: We may use and disclose your health information to obtain payment for services we provide to you.

- Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare Operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

B. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

Name: _____ Date: _____ Claim Number: _____

C. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

D. MARKETING: We will not use your health information for marketing communications without your written authorization.

E. USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are the possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

G. LAW ENFORCEMENT / NATIONAL SECURITY: Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities.

H. APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

- ACCESS TO RECORDS: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we will charge you $0.25 for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

Name: _____ **Date:** _____ **Claim Number:** _____

B. ACCOUNTING OF CERTAIN DISCLOSURES: Upon written request, you have the right to receive a list of instances in which we, or our business associates, disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before **April 14, 2003.** If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right

to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions, we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

D. AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. ELECTRONIC NOTICES: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form as well.

QUESTIONS AND COMPLAINTS:
If you want more information about our Privacy Practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decision we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

CONTACT: Dr. Albert Noble, Enterprise Chiropractic Clinic
FAX: 503-639-2052
E-MAIL: info@drnoble.net

MOTOR VEHICLE COLLISION GENERAL PRECAUTIONS AND INSTRUCTIONS

PATIENT: _____DATE_____

Strong and very rapid forces may be involved in your automobile accident. It is important that you watch for any new symptoms that might be a sign of hidden injury and/or increased inflammation. It is normal to feel soreness, pain, and tightness in your body, often getting worse the second or third days. However, more severe pain and new symptoms such as numbness, tingling, balance issues, and weakness in your arms and legs should be reported to your doctor as soon as possible. Although you may have a lot of soreness, stiffness, and/or pain, most people recover over time.

As a result of a motor vehicle collision, some people feel a general sense of stress or anxiety which can lead to trouble sleeping or irritability. Some people feel like avoiding driving in vehicles for some time. In the majority of cases, these feelings go away within a few days or weeks.

AVOID NEW INJURIES
it is important for the first week or two weeks to avoid any high-risk physical activities or contact sports that may re-injure you and case new injuries. Avoid excessive jarring activities or extreme physical activities, such as heavy lifting.

HOME CARE
It is important to comply with the home recommendations that the doctor gives you. Your doctor will be giving you advice about how important it is to keep physically active during the healing process.

- Do not sit-up in bed watching TV or reading or sit on soft couches. Firmer chairs are advised.
- Avoid twisted positions with your neck and back
- Lie on the floor or bed with your legs and knees bent with a pillow under your knees to reduce back pain
- Change your body position every 30 minutes for the next week
- Do slow and gentle stretches 4-6 times a day for 1-2 minutes. Do not push into moderate or severe pain. Stretches can include sitting shoulder rolls, lying on the floor and gently holding each knee to the chest, and general flexibility motions for the neck and back. As you feel better the stretches can be increased.
- Take short walks every day (start with level surface) for 5-10 minutes and repeat 3-4 times each day. Work up to longer walking periods and gradually increases your walking speed and time. The goal is to get you walking an hour a day. Once you feel better then you can walk up hills.
- Avoid sitting/standing or any awkward positions for prolonged periods for the next two weeks.
- Use good posture and proper body mechanics over the next few weeks.
- Getting an extra 30-60 minutes of extra sleep a night is recommended for the first week. Make certain to get restful sleep.
- Use ice for the 3-4 days. Place a thin towel between the ice pack and your skin and keep the ice on for the prescribed length of time. Do not fall asleep with ice pack on. Neck use ice for 10-15 minutes and the back use 20-30 minutes.
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GOALS OF THIS OFFICE
The primary goal of this office is to restore your ability to return to your normal pre-injury physical activities of daily living; including work, home, sports, and recreational activities. Our office focuses on improving joint and soft-tissue function by providing appropriate therapies to injured areas and thus assisting your body in healing and reducing pain levels and aiding your recovery. Your active participation at home and work is important in the recovery process and your compliance with the appointments and exercise recommendations will improve your outcome.

MONITORING YOUR PROGRESS IS IMPORTANT TO OUR OFFICE

Our office staff will periodically ask you to fill out addition paperwork that is designed to document your response to spinal manipulation and other therapies/procedures and your responses allow our office to determine if your treatment outcome is on track, if your treatment needs to be changed or modified, if further testing is indicated, if a consultation by another health care provider is needed, or if a referral is indicated.

FOLLOW-UP APPOINTMENTS

it is important that you keep all of your appointments and follow all home instructions, including exercise, stretching, use of ice, and watching your posture. Call your doctor if you have any problems. If you miss or do not show-up for two appointments, our office will need to talk to you about your absence and find some way to work with your schedule. If four scheduled appointments are missed the office may refer you to another provider, depending upon circumstances.

Name:_____Date:_____Claim Number: _____

DYANOMETER LECTURA

Mano isquierda	Mano derecha
1.) _____	1.)
2.) _____	2.)
3.) _____	3.)

Promedio para la mano isquierda:
Promedio para la mano derecha :

PHYSICAL EXAMINATION

Altura: _____ Peso: _____ B.P. ____/____Pulso: _____

Fecha de llamada: ECC VERIFICAR NOMBRE DEL EMPLEADO:

MVA PIP Coverage Questions:

Is this a third party insurance or is this the patient's personal insurance? Third party _____Personal_____*(Third Party is only accepted if the injured is not at fault, but has no personal insurance)*
*If you answered **third party** to the above question; did the other insurance company accept liability?_____*
If third party, you must send the signed Doctor's Lien to the adjuster (or lawyer if they have one) and have them sign it and send it back to us

Nombre del paciente :_____

Fecha de nacimiento: _____

Fecha de la lesion:_____

Hablates con:_____

Numero de reclamacion:_____

_____

Numero de poliza (Opcional):_____

PIP Adjuster Name:_____

Numero de telefono w/ext.:_____

Numero de fax:_____

Medical PIP disponible y esta abierto?_____

A que direccion nosotros mandamos/enviamos la factura?_____
_____
_____
_____
_____
_____
_____

Yo verifique y contacte la compania de seguro en la fecha:

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Firma:

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*Grupo de gente en el mismo carro juntos so you can ask all the questions on the same phone call.
*PIP coverage is through your own insurance no matter who is at fault in the ac