CAVALLO CHIROPRACTIC

Patient Information

Today's Date: _____

Personal Information

Name: _____
*LAST *FIRST *M.I.

Address: _____
*STREET ADDRESS APARTMENT/UNIT #

_____
*CITY *STATE *ZIP CODE

Phone Number: (_____) _____ Alternate Phone Number: (_____) _____

Social Security Number: _____ Birth Date: _____ Marital Status: _____

Sex: M F Occupation: _____ E-Mail Address: _____

How did you hear about Cavallo Chiropractic? _____

Insurance Information

Will you be using insurance to help cover your chiropractic care? Y N If no, please skip to the next section.

Is your visit today due to an auto or work related injury? Y N

Insurance Company Name: _____ Claim or Member ID Number: _____

Patient's Relationship to Insured: Self Spouse Child Other: _____

***If self insured:
Name of Employer or School: _____

Employer or School Address: _____
*STREET ADDRESS *SUITE/UNIT #

_____
*CITY *STATE *ZIP CODE

***If NOT self insured:
Name of Spouse/Parent/Other: _____ Insured's Birth Date: _____

Insured's Phone Number: (_____) _____ Insured's Alternate Phone Number: (_____) _____

Employer Address: _____
*STREET ADDRESS *SUITE/UNIT #

_____
*CITY *STATE *ZIP CODE

Medical History

Are you currently under a medical physician's care? Y N Physician's Name: _____

Current Medications: _____

Allergies: _____

Have you ever been in a car accident? Y N If yes, when? _____

Have you ever been to a chiropractor before? Y N

Do you smoke? Y N If yes, how much? _____

Do you drink? Y N If yes, how much? _____

Date of last menstrual period: _____ Are you currently pregnant? Y N

Are you currently experiencing or have you ever had the following conditions? (Please check those that apply.)

_____ Impaired Hearing	_____ Seizures/Epilepsy	_____ Bleeding Disorders
_____ Ringing in Ears	_____ Paralysis	_____ Anemia
_____ Impaired Vision	_____ Numbness in Arms/Legs	_____ Chicken Pox
_____ Headaches	_____ Muscle Weakness	_____ Measles
_____ Shortness of Breath	_____ Difficulty Breathing	_____ Rubella
_____ Palpitations	_____ Anxiety	_____ Depression
_____ Chest Pains	_____ Loss of Appetite	_____ Insomnia
_____ Persistent Cough	_____ Fever	_____ Cancer
_____ Thyroid Problems	_____ Night Sweats	_____ HIV
_____ Asthma	_____ General Fatigue	_____ AIDS
_____ Swelling of Ankles	_____ Bloody Stools	_____ Hepatitis
_____ Nausea/Vomiting	_____ Diabetes	_____ Arthritis
_____ Stomach Ulcers	_____ Pneumonia	_____ Tuberculosis
_____ Difficulty Swallowing	_____ Persistent Diarrhea	_____ Rhuematic Fever
_____ Constipation	_____ Dizziness	_____ Stroke
_____ Difficult/Painful Urination	_____ Fainting Spells	_____ Kidney Disease
_____ Urgent/Frequent Urination	_____ High Blood Pressure	_____ Gallbladder Disease
_____ Significant Weight Loss/Gain		

What is the reason for today's visit? _____

_____

_____

Rate your overall pain today:

0	1 2	3 4	5 6	7 8	9 10
Pain	Mild	Uncomfortable	Moderate	Intense	Unbearable

Certifications

I certify the above information to be true and accurate to the best of my knowledge. I also hereby authorize payment of medical benefits for services provided by Cavallo Chiropractic. I also authorize Cavallo Chiropractic to release information regarding my injury/illness to my referring physician, attorney, and insurance company.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____
[If patient is a minor.]

CAVALLO CHIROPRACTIC

Informed Consent

The law requires us to obtain your informed consent prior to examination and treatment. By signing this document, you are confirming that you have read and/or the doctor has discussed with you the following information; you have had an opportunity to ask questions and all of your questions have been answered fully and satisfactory.

Treatment - An adjustment is performed by the doctor by using his hands or a mechanical device on your body in such a way to move your joints. This procedure may cause an audible "click," much as you may have experienced when you "crack" your knuckles. There are some material risks involved in doing this and they are as follows:

Pain: Most patients come into this office in pain. Rarely will treatment even temporarily increase soreness in the region being treated. However, since it is possible, I am including it in this section.

Rib Fractures: It is possible to "crack" an arthritic rib with an adjustment; this can happen with anyone. It occurs most often on aging patients that have weakened bones from osteoporosis. Osteoporosis is suspected with age, and can be noted on your x-rays. However, these problems occur so rarely that I have not been able to find available statistics to quantify their probability.

Disc Herniation: Occasionally, treatment will aggravate or cause a problem if the disc is in a weakened state. These problems occur so rarely that I have not been able to find available statistics to quantify their probability.

Physical Therapy: Some of the machines that we use generate heat. We also use ice in this office. Burns can possibly come from such treatment. If you have a pace maker or metal in your body, please notify the doctor prior to therapy. These problems occur so rarely that I have not found any statistics to quantify its probability.

Stroke: Strokes are not that common, and even less so in a chiropractic office. They are so rare that you have a greater chance of being hit by lightening (more than one in a million). This office reduces your odds even further through screening test during the examination.

Other Problems: There may be other problems or complications that might arise from treatment; other treatment such as massage, traction, etc. can be prescribed as a result. These other problems or complications are so infrequent, that it is not plausible to anticipate and/or explain them in advance of your treatment.

Non-Treatment: Remaining untreated or non-compliancy can result in adhesions, pain and reduction in associated joint mobility. The probability that these adhesions and pain will interfere with motion, function and quality of life is almost certain.

I hereby state that I have read, or have had read to me, and fully understand this consent form. I authorize and direct Dr. Louis J. Cavallo and his assistants to provide such additional services as they deem reasonable and necessary.

Patients Printed Full Name: _____

Patient's Signature: _____ Date: _____

Guardian's Signature [If patient is a minor.]: _____

Witness' Signature: _____ Date: _____

CAVALLO CHIROPRACTIC

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Your protected health information may also be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Opportunities: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the reception desk where you will be asked to sign in for your appointment. We may also call you by name in the waiting room when your physician is ready to see you. We may also use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or to reschedule a missed appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues; as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmates; Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Use and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

2. Patient Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as you described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.*

*Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You have the right to have your physician amend the protected health information. If we deny your request for an amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

Cavallo Chiropractic reserves the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by Cavallo Chiropractic. You may file a complaint with us by notifying Dr. Louis Cavallo.

4. Signature

Cavallo Chiropractic is required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with Doctor Louis J. Cavallo in person or by phone at (303) 678-8555.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Patient's Signature Date