FLYNN CHIROPRACTIC

Timothy G. Flynn, D.C.

NEW PATIENT INFORMATION

Welcome to our office! Please complete all questions. Thank you!

Name:			Case#:	Date:	Male Female
Address:			City:	State:	Zip Code:
Home Phone:		Work Phone:		Cell Phone:	
E-mail:					
Date of Birth:	Age:	Social Security No.:			Marital Status: M W D S
Occupation:			Employer:		
Address:		City:		State:	Zip Code:
Spouse's Name:			Spouse's Employer:		
Children's Name and Ages:					
Favorite Hobbies or Interests:					
Method of Payment: ☐ Cash ☐ Check ☐ Visa ☐ Master card ☐ Gift Certificate					

Current health complaints:

1._____
2._____
3._____
4._____
5._____

Who may we thank for referring you? _____

Have you had similar problem(s) before? ☐ Yes ☐ No

If yes, for how long? _____

Is this the result of an auto or work injury? ☐ Yes ☐ No

If yes, when? _____

Father, Mother, Brother, Sister or Children with similar problems? ☐Yes ☐ No

If yes, who? _____

Other doctors you have seen for this problem?

_____

Surgeries you have had? _____

Medications you currently take? _____

Is there a chance that you are pregnant? Yes No

Have you ever been diagnosed with cancer? Yes No

If yes, what kind? _____

Do you have health insurance? Yes No

Name of Company _____

The above information is true and accurate to the best of my knowledge. I authorize the release of any medical or other information necessary to process insurance claims and assign any insurance benefits for care provided be paid directly to this office.

Patient or Guardian Signature_____Date:_____

1042 W James St #101 * Kent, WA 98032
Phone: 253-852-3770 Fax: 253-852-3913

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Health History

Patient Name: _____ File #: _____ Date: _____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully, as these problems can affect your overall course of chiropractic care.

CIRCLE ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

Pneumonia	Mumps	Influenza		**INTAKE**
Rheumatic Fever	Smallpox	Pleurisy		Coffee
Polio	Chicken Pox	Arthritis		Tea
Tuberculosis	Diabetes	Epilepsy	Alcohol	
WhoopingCough	Cancer	Mental Disorders	Cigarettes	
Anemia	Heart Disease	Lumbago		White Sugar
Measles	Thyroid	Eczema		

CIRCLE ANY OF THE FOLLOWING DISEASES YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL CODE
Low back pain
Pain between shoulders
Neck pain
Arm pain
Joint pain/ stiffness
Walking problems
Difficulty chewing/ Clicking jaw
General stiffness

Gas/ bloating after meals
Heartburn
Black/bloody stool
Colitis

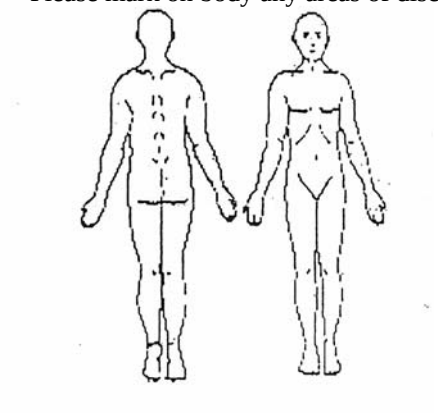
GENITO-URINARY CODE
Bladder trouble
Painful/ excessive urination
Discolored urine

Prostate/ sexual dysfunction
Other problems:
_____
_____
_____

NERVOUS SYSTEM CODE
Nervous
Numbness
Paralysis
Dizziness
Forgetfulness
Confusion/ depression
Fainting
Lung problems
Stroke
Cold/tingling extremities
Stress

C-V-R CODE
Chest pain
Short breath
Blood pressure problems
Irregular heartbeat
Heart programs
Varicose veins
Ankle swelling

Please mark on body any areas of discomfort or pain:



EENT CODE
Vision problems
Dental problems
Sore throat
Earaches
Hearing difficulty
Stuffed nose

GENERAL CODE
Fatigue
Allergies
Loss of sleep
Fever
Headaches

GASTROINTESTINAL CODE
Poor/ excessive appetite
Liver Problems
Excessive thirst
Frequent nausea
Vomiting
Diarrhea
Constipation
Hemorrhoids
Gall bladder problems
Weight trouble

FEMALES ONLY:
When was your last menstrual cycle?_____
Are you Pregnant? __Yes ___ No

MALE/ FEMALE CODE
Menstrual irregularity
Menstrual cramps
Vaginal pain/ infection
Breast pain/ lumps
Abdominal cramps

FAMILY HISTORY
These family members have the same or similar problem(s):
Mother
Father
Brother
Sister
Spouse
Child

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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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

- **Treatment** means providing, coordination, or managing health care and related eservices by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing for chiropractic services.

- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected information may also be used by our office to recommend treatment alternatives or to provide you with information about health related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities or Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence,. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request except to the extent that we have already taken restrictions relying on your authority.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to you Privacy officer at the practice address listed below.

- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy you're protected health information, with limited exceptions. A reasonable fee may be assessed.

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- The right to request an amendment to your protected health information. We may however deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment or health care operations… or based on your precious authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.
- The right to request restrictions on certain uses or protected health information, including those related to disclosure to family members, other relatives, close personal friends, r any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

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

This notice is effective as of April 14 2003, and we are required to abide by the terms of the Notice of Privacy practices currently in effect. WE reserve the right to change the terms of your Notice of Privacy Practices and to make the new notice provisions effective for all privileged health information that we maintain. Revision to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revise Notice from this office.

You have the right to file a formal, written complaint with us at the address below or with the Department of Health and Human Services, Office of Civil rights in the even you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For More information about our Privacy Practices, Please contact:

Privacy Officer:	Timothy Flynn, D.C.
Office Name:	Flynn Chiropractic
Address:	1042 W. James St Ste. 101
City, State, Zip	Kent, WA 98032
Phone:	253-852-3770

For more information about HIPAA or to file a complaint:
The US Dept. of Health and Human Services
Office of Civil Rights
200 Independence Avenue S.W.
Washington, D.C. 20201
877-696-6775

Patient Name:_____File #: _____ Date:_____
(Please Print)
Signed:_____

Terms of Acceptance

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When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will alert you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others.

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature: _____ File#_____ Date: _____

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