Background And Personal Information

Name (last)_____ (first)_____ (mi)_____ Pronouns _____

How would you like to be addressed?_____ Birthdate_____/_____/_____ Age _____

Home Address (street)_____

(city)_____ (state)_____(zip)_____

Phone Number (_____) _____ Email Address _____

Employer_____ Occupation_____

Male / Female (biological gender) Single / Married / Partnered / Divorced / Widowed / Separated

Partner's Name _____ Number of Children _____ Names and Ages _____

_____

Employer_____ Work Phone_____

Emergency Contact_____ Phone_____

Whom may we thank for referring you to Alternative Space Chiropractic?_____

Reason for consulting ASC?_____

_____

_____

Previous Chiropractic: YES/NO If yes, date of last adjustment _____ Name of chiropractor_____

Reason for ending care:_____

Are you currently receiving medical attention and if so, for what?_____

_____

Please list any medications you are currently taking (prescription and non-prescription):_____

_____

_____

Please briefly describe your daily routine, including meals, snacks, supplements, and sleep _____

_____

_____

What are your daily exercise habits?_____

_____

What are your current play/relaxation activities?_____

_____

How would you rate your current health? Poor Fair Average Good Excellent

How would you describe your family's health? Poor Fair Average Good Excellent

Are you healthier now than you were 5 years ago? Y / N Why?_____

Do you know the health history of your birth? Y / N Home _____ Hospital _____ Natural _____ Intervention

Many things can contribute to imbalance in the body. Below are some of the most common causes. Please check any that apply or have applied to you in the past. State when if applicable.

Physical Stress	Emotional Stress	Chemical Stress
___ Birth Trauma	___ Relationships	___ Environmental
___ Slip/Fall	___ Career	___ Smoker
___ Car Accidents	___ Family	___ 2nd hand smoke
___ Sports Injuries	___ Financial	___ Caffeine
___ Physical Abuse	___ Pace of Life	___ Alcohol
___ Heavy Physical Labor	___ Quick temper	___ "Diet/sugar-free" food
___ Poor Posture	___ Holding in feelings	___ Soda intake
___ Heavy computer use	___ Perfectionism	___ Prescription drugs
___ Repetitive movements	___ Procrastination	___ Junk food
___ Prolonged driving/standing	___ Depression	___ Recreational drugs

What do you feel is the primary stress in your life?_____

Why is your health important to you (how will your life be better and what will you do once you reach your health goals)?

_____

_____

Financial Information: Who is responsible for this account with Alternative Space Chiropractic?_____

Is there anything else you would like us to know?_____

Joshua Pickell DC does not offer to diagnose or treat any symptom or condition. Our purpose is to help your body express its innate ability to heal by removing what is interfering with your innate intelligence. These interfering patterns are called subluxations. If a non-chiropractic finding arises, you will be informed and referred to an appropriate health care provider.

I, _____ , have answered the above questions to the best of my knowledge. Based on the information provided, I grant Joshua Pickell, DC permission to assess, locate, and release my subluxation patterns.

Your signature _____ **Date**_____

HIPAA PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Alternative Space Chiropractic (ASC) is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health and the care you receive. The creation of a record detailing the care and services 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.

NO CONSENT REQUIRED

ASC may use and/or disclose your PHI for the purposes of:

(A) Payment - In order to get paid for services provided to you, the Health Center will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.

(B) Health Care Operations - In order for ASC to operate in accordance with applicable laws and to provide quality and efficient care, it may be necessary for ASC to compile, use and/or disclose your PHI. ASC may use and/or disclose your 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) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(c) Emergency Situations -

• (i) for the purpose of obtaining or rendering emergency treatment to you provided that ASC 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.

(d) Communication Barriers - If, due to substantial communication barriers or inability to communicate, ASC has been unable to obtain your Consent and the doctor determines, in the exercise his professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(e) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(f) Abuse, Neglect or Domestic Violence - To a government authority if ASC is required by law to make a disclosure. If ASC 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.

(g) Health Oversight Activities - 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.

(h) Judicial and Administrative Proceeding - For example ASC may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(i) Law Enforcement Purposes - In certain instances, your 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, ASC may disclose your PHI if the Health Center believes that your death was the result of criminal conduct.

(j) Coroner or Medical Examiner - ASC may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(k) Organ, Eye or Tissue Donation - If you are an organ donor, ASC may disclose your PHI to the entity to whom you have agreed to donate your organs.

(l) Research - If ASC 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 and that does not identify you and, even without your name, cannot be used to identify you.

(m) Avert a Threat to Health or Safety - ASC 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.

(n)Workers' Compensation - If you are involved in a Workers' Compensation claim, ASC may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

Appointment Reminders
• Your provider or a staff member may use your information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call. This may also be a text message to the number you provided.
• You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

AUTHORIZATION
Uses and/or disclosures, other than those described above, will be made only with your written Authorization. You may revoke your authorization to us at any time; however, your revocation must be in writing. You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, ASC is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request. In your written request, you must inform ASC of what information you want to limit, whether you want to limit ASC's use or disclosure, or both, and to whom you want the limits to apply. If ASC agrees to your request, they will comply with your request unless the information is needed in order to provide you with emergency treatment.

You Have a Right to
(a) Inspect and obtain a copy your PHI. To inspect and copy your PHI, you are requested to submit a written request. ASC can charge you a fee for the cost of copying, mailing or other supplies associated with your request.
(b) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to ASC. ASC will accommodate all reasonable requests.
(c) Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.
(d) Receive an accounting of disclosures of your PHI. The request should indicate in what form you want the list (such as a paper or electronic copy)
(e) Receive a paper copy of this Privacy Notice from ASC upon request.
(f) Request copies of your PHI in electronic format.
(g) Receive notice of any breach of confidentiality of your PHI from ASC

ASC'S REQUIREMENTS
• Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice their legal duties and privacy with respect to your PHI.
• Is required to abide by the terms of this Privacy Notice.
• Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
•Will distribute any revised Privacy Notice to you prior to implementation.
•Will not retaliate against you for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of ASC's "NOTICE OF PRIVACY PRACTICES." I acknowledge that I was provided a copy of the Notice of Privacy and that I have read them or declined the opportunity to read them and understand the Notice of ASC. I understand that this form will be placed in my patient chart and maintained for six years.

_____
Name (Printed)

_____ _____
Signature: Patient or Legal Representative (Attorney, Guardian, Parent) Date Signed

Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form

1. Alternative Space Chiropractic's Privacy Notice has been provided to me prior to signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ('PHI') necessary for ASC to provide treatment to me, and necessary for ASC to obtain payment for that treatment and to carry out its health care operations. ASC explained to me that the Privacy Notice will be available to me in the future at my request. ASC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing consent.

2. ASC reserves the right to change the privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following communications that will be used by ASC: a) calling and leaving voice messages on my phone or with the individual answering the phone, b) text messaging to my mobile phone, c) messages, tags, comments, likes, or other interactions on social media accounts provided by me, d) a card, letter, or other written information mailed to me at the address provided by me; e) sending an electronic mail to the address provided by me.

4. ASC may use and/or disclose my PHI in order for ASC to treat me and obtain payment for that treatment, and as necessary for ASC to conduct its specific health care operations.

5. I understand that I have a right to request that ASC restricts how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, ASC is not required to agree to any restrictions that I have requested. If ASC agrees to requested restrictions, then the restriction is binding on ASC. 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 the ASC has already taken action in the reliance on this consent.

6. 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 the ASC has already taken action in the reliance on this consent.

7. 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, ASC will not treat me. I further understand that if I revoke this consent, at any time, ASC has the right to refuse to treat me.

8. ASC may maintain a directory of and sign-in log of individuals seeking care and treatment in this office. This information may be seen by and is accessible to others who are seeking care or services in ASC's practice.

I acknowledge that I have received a copy of ASC's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted at the front desk.

We are 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. Your signature below is acknowledgment that you have received the Notice of Privacy Practices, and all of your questions have been answered to your full satisfaction in a way that you can understand.

_____

Name (Printed)

_____ _____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent) Date Signed

Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various forms of soft-tissue assessment and release techniques, and subtle energy rebalancing on me (or on the person named below for whom I am legally responsible) by Joshua Pickell, DC, or any Doctor of Chiropractic working with, associated with, or covering at Alternative Space Chiropractic.

I have had the opportunity to discuss with the doctor and/or with other personnel the nature and purpose of chiropractic adjustments. I understand and am informed that, as in the practice of medicine, there are some risks assumed in receiving care and treatment, including, but not limited to, sprains, fractures, disc injury, stroke and dislocations. I wish to rely on the doctor to exercise professional judgment during the course of any procedure which, based on the facts then known, is in my best interest.

Chiropractic care involves the science, philosophy and art of locating and adjusting interference patterns and misalignments and is oriented toward improving spinal, neurological, and muscular functions. There has been no promise, implied or otherwise, of a cure for any specific symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use their hands or a mechanical device upon my body to adjust joints and release muscles.

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were provided.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____

Name (Printed)

_____ _____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent) Date Signed

_____ _____

Doctor's Signature Date Signed