

Registro Del Paciente

Nombre _____ Apellido _____ Numero de Seguro Social ____ - ____ - ____

Fecha de Nacimiento: ____/____/____ Edad: ____

Direccion: _____
Numero y Calle Ciudad Estado Codigo Postal

Numeros de Telefono: (____) ____ - ____ (____) ____ - ____ (____) ____ - ____
Casa Trabajo Celular

Direccion de Correo Electronico: _____

Trabajo o Profesion: _____ Lugar de Empleo: _____

Direccion de Empleo: _____
numero y calle Ciudad Estado Codigo Postal

Esta visita es resultado de: ____ accidente de auto ____ accidente de trabajo ____ Otro

Tienes seguro medico? Si No Que compañía? _____

Nombre del Asegurado: _____ Relacion: _____

Numero de Identificacion: _____ Numero de Grupo: _____

Tienes Abogado? Si No Nombre Y Telefono: _____ (____) ____ - ____

Como fuiste recomendado/a: _____

Es: Casado__ Soltero__ Viudo__ Divorciado__ # de Hijos__

Porque razon vienes a nuestra oficina? _____

Has estado hospitalizado? Si No Porque razon: _____ Por cuanto tiempo? _____

Has sido sometido/a a alguna cirugia? Si No De que tipo? _____

Estas tomando medicamento o vitaminas Si No Nombres: _____

Mujeres Solamente: Estas embarazada? Si No Cuantos meses? __ # de embarazos: __

Ultima menstruacion: ____/____ Te has hecho la histerectomia? Si No

Has estado bajo tratamiento Quiropractico? Si No

Cuando fue la ultima ves que fuiste? ____/____

Tienes problems medicos del:

Corazon	<input type="checkbox"/> Si	<input type="checkbox"/> No
Vesicula	<input type="checkbox"/> Si	<input type="checkbox"/> No
Riñones	<input type="checkbox"/> Si	<input type="checkbox"/> No
Tiroide	<input type="checkbox"/> Si	<input type="checkbox"/> No
Higado	<input type="checkbox"/> Si	<input type="checkbox"/> No
Otro:	_____	

Marque si alguno de los siguientes le aplican:

Problema:	Pasado	Presente	Problema	Pasado	Presente
Infecion Urinaria	_____	_____	Prostata	_____	_____
Fiebre	_____	_____	Urinacion Freguente	_____	_____
Sida	_____	_____	Peso abnormal	_____	_____
Diabetis	_____	_____	Problemas de digestion	_____	_____
Uso de Steroides	_____	_____	Dolor de espalda	_____	_____
Pildoras de Control Natalidad	_____	_____	Dolor de cuello	_____	_____
Alta Presion	_____	_____	Dolor de cintura	_____	_____
Artritis	_____	_____	Dolor de cabeza	_____	_____
Desmayos	_____	_____	Dolor de huesos	_____	_____
Retencion urinaria	_____	_____	Uso de tabaco	_____	_____
Trauma	_____	_____	Uso de alcohol	_____	_____
Cancer/Tumor	_____	_____	Mareos	_____	_____

Historial de familia:

Cancer	<input type="checkbox"/> Si	<input type="checkbox"/> No	Quien? _____
Diabetis	<input type="checkbox"/> Si	<input type="checkbox"/> No	Quien? _____
Alta Precion	<input type="checkbox"/> Si	<input type="checkbox"/> No	Quien? _____
Problema Cardiovascular	<input type="checkbox"/> Si	<input type="checkbox"/> No	Quien? _____
Colesterol	<input type="checkbox"/> Si	<input type="checkbox"/> No	Quien? _____

Sodas por dia _____ Tazas de cafe por dia _____

3 personas que te conoscan y que no vivan con tigo en casa:

<u>Nombre</u>	<u>Relacion</u>	<u>#de Telefono</u>
_____	_____	(____) _____ - _____
_____	_____	(____) _____ - _____
_____	_____	(____) _____ - _____

He leído y entiendo El Acto de La Poliza de Privacion fijado que describe mi derechos de paciente con respecto como la informacion medica sobre mi puede ser utilizada y como tengo acceso a esta informacion. Convengo los terminos y las condiciones dispuestos.

X _____
Firma

_____/_____/_____
Fecha

Nombre: _____

Fecha: _____

Favor de indicar en las figuras de abajo en que parte de su cuerpo esta sintiendo dolor, ponga la letra donde actualmente esta sintiendo el tipo de dolor.

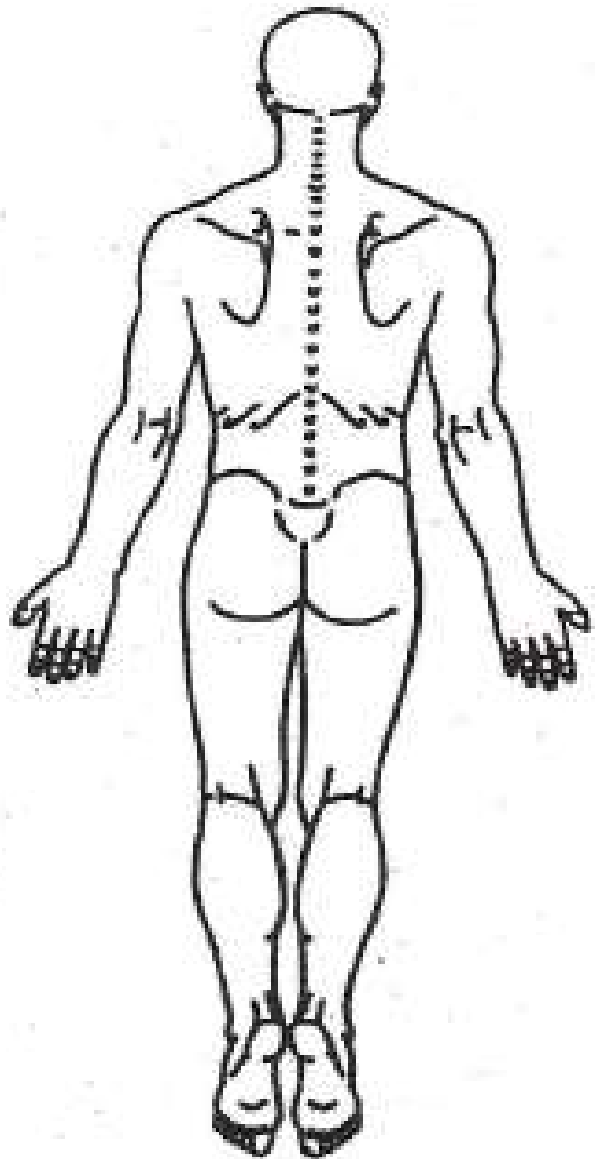
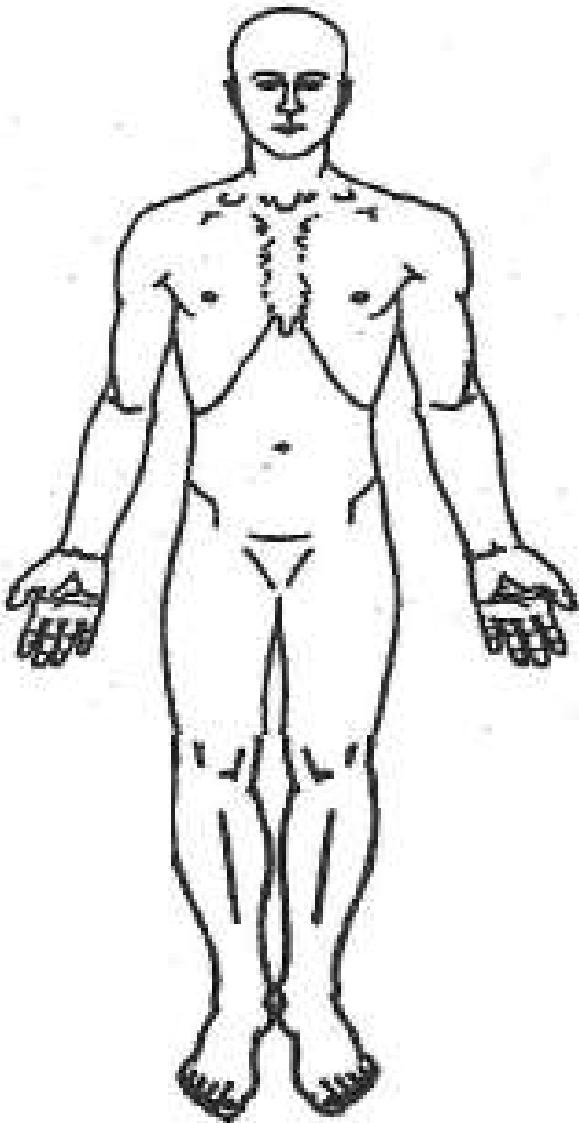
Entumecimiento: E

Dolor Agudo: G

Cosquilleo: C Dolor: D

Tension: T

Ardor: A



Electronic Health Records Intake Form

En conformidad con requisitos para el programa incentivo EHR del gobierno

Nombre: _____	Apellido: _____
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Correo Electronico: _____@_____

Estatura(ft): _____ Peso(lbs): _____

Medio de comunicacion preferible (Elija uno): Correo Electronico / Telefono / Correo

Fecha de Nacimiento: __/__/__ Sexo: Masculino / Femenino Idioma preferido: _____

Fumador Activo:Diario/ Ocasional/ Pasado / Nunca Fecha Inicial de Fumador Activo: _____

CMS requiere que el proveedor reporte nacionalidad y raza

Raza (Elija una): American Indian or Alaska Native / Asian / Black or African American /
Blanco(Caucasian) Native Hawaiian or Pacific Islander / Me reuso a contestar

Nacionalidad (Elija una): Hispano o Latino / No Hispano o Latino / Me reuso a contestar

Esta tomando medicamento? (Favor de incluir medicina que no requiera receta)

Nombre del Medicamento	Dosis y Frecuencia (ejm. 5ml 2 veces al dia)

Tiene alergias a algun medicamento?

Nombre del Medicamento	Reaccion	Fecha de Inicio	Comentarios adicionales

Decido recibir el resumen de mi visita clinica(*Estos resúmenes estan usualmente en blanco por la frecuencia del cuidado chiropractico.*)

Firma del Paciente: _____ Fecha: _____

Uso de la Oficina solamente	Presion Sanguinea: _____ / _____	Pulso: _____
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Healing Touch Chiropractic and Rehab 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.

Healing Touch Chiropractic and Rehab is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or health care operations. (example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care professionals associated with Healing Touch Chiropractic and Rehab."

"It is our policy to provide a substitute health care provider, authorized by Healing Touch Chiropractic and Rehab, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. Your file, containing protected health care information, may be reviewed by the designated collection agency or authority.

Worker's Compensation

If applicable, we may disclose your health information as necessary to comply with state Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation & Research

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues, or to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing and Other Communications

We may contact you for marketing purposes or fundraising purposes, as described below:

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment."

"It is our practice to occasionally participate in charitable events. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will inform you of the type of activity, the dates and times, and request your participation in such event. It is not our policy to disclose health information about you for the purpose of Healing Touch Chiropractic and Rehab's sponsored fund-raising events."

Change of Ownership

In the event that Healing Touch Chiropractic and Rehab is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restriction on certain uses and disclosures of your health information. Please be advised; however, that Healing Touch Chiropractic and Rehab is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Healing Touch Chiropractic and Rehab amend your protected health information. Please be advised; however, that Healing Touch Chiropractic and Rehab is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Healing Touch Chiropractic and Rehab.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon your request.

Changes to this Notice of Privacy Practices

Healing Touch Chiropractic and Rehab reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Healing Touch Chiropractic and Rehab is required by law to comply with this Notice.

Healing Touch Chiropractic and Rehab is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Grace Ryoo by calling the main office at 623-521-8190. If Grace Ryoo is not available, you may make an appointment for a personal conference in person or by telephone within two working days.

Complaints

Complaints about your privacy rights or how Healing Touch Chiropractic and Rehab has handled your health information should be direct to Grace Ryoo by calling the main office at 623-521-8190. If Grace Ryoo is not available, you may make an appointment for a personal conference in person or by telephone within two working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of ____/____/____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Healing Touch Chiropractic and Rehab with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date