

Southgate Chiropractic Center



GENE T. ELSESSER D.C.
13424 DIX-TOLEDO ROAD
SOUTHGATE, MICHIGAN 48195
PHONE (734) 283-8700

TERMS OF ACCEPTANCE

When a person seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards 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 it's 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 examination, we encounter non-chiropractic or unusual findings, we will advise 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.
(Printed Name)

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)

(Date)

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Acknowledgement of Receipt of Notice of Privacy Policy / Signature on File

I acknowledge that the Southgate Chiropractic Center "Notice of Privacy Practices" has been provided to me. The Notice of Privacy Practices described the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of Southgate Chiropractic Center. It describes my rights as they concern the limited use of health information, including my demographic information, collected from me and created or reviewed by Dr. Elsesser. The Notice of Privacy Practices for Southgate Chiropractic Center can be requested at the desk of this practice and at www.southgatechiropractic.com.

I also authorize use of this form on all my insurance submissions. I authorize payment directly to Gene T. Elsesser, D.C., and understand that I am responsible for my bill.

Southgate Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Description of Personal Representative's Authority



Notice of Privacy Practices

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this office. It also describes our policies concerning the use and disclosure of this information 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, that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by Federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website at www.southgatechiropractic.com, or asking for one at the time of your next appointment or calling the office and requesting that a revised copy be sent to you at your expense via USPS.

1. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information (PHI) by Dr. Elsesser, 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.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. Your PHI may 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 PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend.

Healthcare Operations: We may use or disclose your PHI, as necessary, to notify you of an appointment, missed appointment, holiday or birthday. The notice may be delivered via email, telephone, or USPS. You have the right to decline any or all of the fore mentioned notifications. Your request must be specific and in writing on file in our office.

Other uses and disclosures of your PHI will be made **only** with your written authorization, unless otherwise permitted or required by law.

2. Your Rights

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

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You have the right to inspect and copy your PHI. You may inspect and obtain a copy of your PHI for as long as we maintain this information. You may be charged a fee for the expense of copying and delivery of your request. Under federal law, however, you may not inspect or copy information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. You may not inspect or copy PHI that is subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. Please contact Dr. Elsesser if you have questions about access to your medical record.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Dr. Elsesser is not required to agree to a restriction that you may request. If Dr. Elsesser believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted.

You may have the right to have Dr. Elsesser amend your PHI. This means you may request an amendment of the PHI about you for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for 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 PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you or to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe.

3. Complaints

You may complain to us or to the Secretary of Health & Human Services if you believe your privacy rights have been violated by us. You may contact Dr. Elsesser, our Privacy Contact or a staff member at 734-283-8700 or at www.southgatechiropractic.com for further information about the complaint process. We will not retaliate against you for filing a complaint.

This notice was published & becomes effective on April 23, 2003.

Keep this for your personal records - *Notice of Privacy Practices*, Page 2/2

Patient Introduction Card

Date _____

Name _____ Married _____ Single _____
(last) (first) (middle)

Address _____ Phone _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Number of Children _____
(month) (day) (year)

Occupation or Profession _____

Employed by _____ Business Phone _____

Name of Spouse _____ Their Health _____

Briefly Describe Complaint _____

Referred by _____ Have you had chiropractic before? _____ Date _____

Have you health insurance? _____ What company? _____

Do you have a major medical reimbursing insurance? _____ What company? _____

Is your problem due to a recent auto accident or workmen's compensation injury _____
 Failure to notify us may jeopardize your claim.

Social Security Number _____

Do you have any difficulty with the following: If YES, mark X

- | | | |
|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Shooting head pains | <input type="checkbox"/> Grating in neck | <input type="checkbox"/> Liver trouble |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Tightness of shoulder muscles | <input type="checkbox"/> Gall bladder trouble |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Neuritis in shoulders and arms | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Pins and needles in arms & hands | <input type="checkbox"/> Intestinal gas |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Tightness of throat | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bladder trouble |
| <input type="checkbox"/> Inflammation of throat | <input type="checkbox"/> T.B. | <input type="checkbox"/> Menstrual cramps & pain |
| <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Heart pain | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Face flushed | <input type="checkbox"/> Heart palpitation | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Twitching of face | <input type="checkbox"/> Heart attacks | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anemia | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Head feels too heavy | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nervous stomach | <input type="checkbox"/> Slipped disc |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Pinched nerves in back |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Pins and needles in legs |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Nerves and nervousness | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Wear glasses | <input type="checkbox"/> Inner tension | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Irritability | <input type="checkbox"/> Pains in legs & feet |

ANY FALLS, ACCIDENTS, INJURIES?

Yes No

If yes, please explain _____

SURGERY? Yes No

If yes, please give kind and date _____

COMMENTS: _____

Medication taken, if any _____
