Confidential Patient Data

PATIENT INFORMATION: Today's Date: _____

Name: _____ Date of Birth: _____ Age: ____ ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Soc. Security #: _____ Marital Status: ☐ married ☐ divorced ☐ single ☐ other
Nearest Relative: _____ Relationship: _____ Phone : _____
Primary Care Physician: _____ Phone: _____
Referred to us by: ☐ ART website ☐ internet ☐ Facebook ☐ Back in Action Website
☐ Friend/family - name: _____ ☐ Doctor: _____
Occupation: _____ Employer: _____

PRESENT ILLNESS:

Primary Complaint: _____
Date of Injury: _____ How did it occur?: _____
_____
Is pain: ☐ constant ☐ intermittent ☐ occasional
Quality of pain: ☐ sharp ☐ achy ☐ numbness ☐ burning ☐ tingling
Is injury work related? ☐ Yes ☐ No Is injury related to a car accident: ☐ Yes ☐ No
Goal of your treatment: ☐ Stop pain ☐ Improve function ☐ Get out of work

PAST MEDICAL HISTORY:

SURGICAL HISTORY:
1. _____ Date: _____
2. _____ Date: _____
Do you have any metal in your body? ☐ Yes ☐ No Current weight: _____ height: _____
ACCIDENT HISTORY: ☐ job ☐ auto ☐ other Date: _____ To what area: _____
☐ job ☐ auto ☐ other Date: _____ To what area: _____
Medication Allergies: _____
Current Medications: _____

SOCIAL HISTORY:

☐ smoke, amount _____ ☐ alcohol, amount _____
Exercise: ☐ running ☐ walking ☐ swimming ☐ biking ☐ weight training ☐ yoga ☐ other: _____
Frequency of exercise: _____
Current sport: _____ Amount of time played: _____

FAMILY HISTORY:

Cancer :	☐ mother	☐ father	☐ grandparent	☐ Self
Diabetes:	☐ mother	☐ father	☐ grandparent	☐ Self
Heart Disease:	☐ mother	☐ father	☐ grandparent	☐ Self
Hypertension:	☐ mother	☐ father	☐ grandparent	☐ Self
Epilepsy:	☐ mother	☐ father	☐ grandparent	☐ Self
Stroke:	☐ mother	☐ father	☐ grandparent	☐ Self

REVIEW OF SYSTEMS: (check all that you currently have or have had in the past)

General
- ☐ allergy
- ☐ convulsion
- ☐ dizziness
- ☐ fainting
- ☐ fatigue
- ☐ headache
- ☐ sleep loss
- ☐ weight loss
- ☐ nervousness

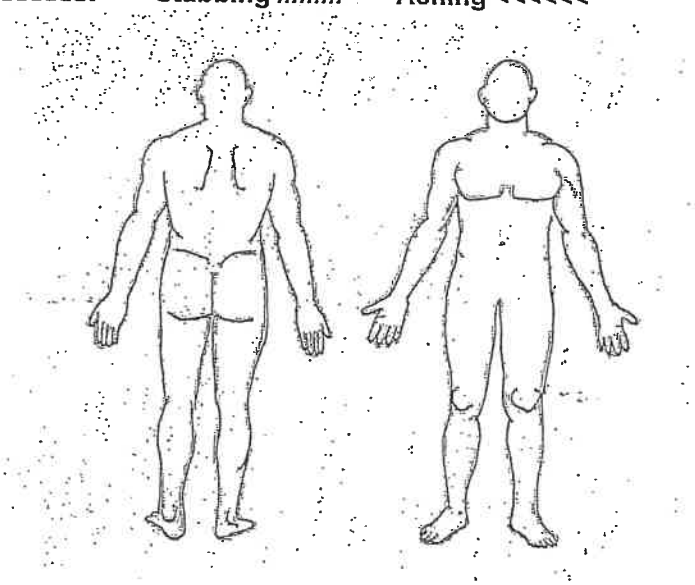
Musculoskeletal
- ☐ arthritis
- ☐ bursitis
- ☐ hernia
- ☐ low back pain
- ☐ neck pain
- ☐ shoulder pain
- ☐ numbness/tingling
- ☐ sciatica
- ☐ scoliosis

Sports Injuries
- ☐ concussion
- ☐ fracture _____
- ☐ break _____
- ☐ sprain/strain _____
- ☐ tear _____

PAIN DRAWING:

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the descibed sensations(s). Use the appropriate symbol(s), mark areas of radiating pain and include all affected areas.

Numbness---------- **Pins & Neddles oooooo** **Burning xxxxxxx** **Stabbing IIIIIIII** **Aching <<<<<<**



VISUAL ANALOGUE SCALE

Please mark on the line the pain level that most accurately represents your pain:

NO PAIN: 0 1 2 3 4 5 6 7 8 9 10 UNBEARABLE PAIN

a) Right Now _____

b) Average Pain _____

c) At Best _____

d) At Worst _____

Back In Action
Athletic Performance Training Center
52 Highland Ave, Suite E
Bethlehem, PA 18017

Insurance Authorization and Assignment

NOTE: While we will process your claim this is not a guarantee of payment. Any charge not covered by the insurance will remain the patient's/guarantor's responsibility. Copay/estimated portion is payable when services are rendered.

I request that payment of authorized Medicare/Other insurance company benefits be made to me on behalf of Donna CopertinoDC,DACRB/ Micheal Travis,DC for any service furnished to me by that party who accepts assignments/physicians. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of me to release to the Social Security Administration and Health Care finance Administration or its intermediaries or carriers any information needed for this or a related Medicare/other Insurance Company claim.
I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts the assignment. I understand it is mandatory to notify the healthcare provider of another party who may be responsible for paying my treatment.(Section 1128B of the Social Security Act and 31 U.S. C 3801-3812 provides penalties for withholding this information).

Insurance Company:_____ Policyholder::_____

Signature:_____ Date:_____

Authorization for Chiropractic Care

The practice of chiropractic includes many standard examination and testing procedures. These include physical examination, orthopedic and neurologic testing, palpation, specialized instrumentations, laboratory tests, radiology examinations, physical therapy and rehabilitative proceduresAdditionally, there is a procedure unique to the chiropractic profession-the chiropractic spinal adjustment.

Adjustments are made by chiropractors to correct spinal and extremity joint subluxation. One of the most common disturbances to the nervous system is the vertebral subluxation. This condition exists where one or more vertebrae in the spine are misaligned sufficiently to cause interference and/or irritation of the nervous system. The primary goal in chiropractic care is the removal of nerve interference caused by such subluxation(s)..

Not only should you understand the benefits of chiropractic care in restoring and maintaining good health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care but should be considered in making the decision to receive chiropractic care. All health care procedures, including those used in varying degrees, have some risks associated with them. Risks associated with chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome (VAS), including stroke and perhaps, death through complicating factors.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of the care, and the risk of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences,and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED TO ME AND ALL QUESTIONS WHICH I HAVE ASKED TO HAVE BEEN ANSWERED TO MY SATISFACTION.

HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE DONNA COPERTINO DC,CSCS,DACRB/ MICHEAL TRAVIS DC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Signature:_____ Relationship:_____ Date:_____

Patient/ Guardian

BACK IN ACTION
Dr. Donna M. Copertino, D.C.

I understand that it is important that Back In Action Chiropractic Rehabilitation/Dr. Donna Copertino, be able to contact me VIA telephone in order to confirm appointments and review test results.

I, _____, do hereby authorize Back In Action/Dr. Donna Copertino, to call my home to confirm or cancel appointments and to release results of testing such a MRI, X-ray, Lab Work, ect.

In my absence, I authorize the above information to be released to the following:

___ Spouse: _____

___ Child: _____

___ Other: _____

___ Answering Machine

I understand that should I decide to revoke this authorization, I must do so in writing.

Signature: _____ Date: _____
(patient/guardian)

No show fee:

There is a no show fee of $50 per 15 min for every apt not canceled within 24 hours of appointment time.

_____ Date: _____
Patient Signature.

Donna M Copertino P.C.
Back In Action
Athletic Performance Training Center
52 Highland Ave, Suite E
Bethlehem, Pa 18017

Consent to use Protected Health Information

Acknowledgement for consent to use and disclosure of Protected Health *Information*

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Donna M Copertino,P.C. or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by the office. I Have received a copy of the Notice of Patient Policy.

_____ ***Patient Initials***

Requesting a Restriction on the Use or Disclosure of your Information

- You may request a restriction on the use or disclosure of your Protected Health Information
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of treatment in Open or Common Areas
Describe and Notify private areas available upon request.

Revocation of Consent
You may revoke this consent to the use or disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information

_____ _____
Patient or Legally Authorized Individual Signature *Date*

_____ _____
Print Patient's full Name *Time*

_____ _____
Witness *Date*

Back in Action

52 Highland Ave - Ste E
Bethlehem PA 18017

Notice of Patient Privacy Policy

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.

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is: Donna M. Copertino, DC, DACRB

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 clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "Protected Health Information" (PHI) 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 www.drbackinaction.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. 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 by your doctor, 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. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- **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 that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information 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.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

- **Payment:** Your protected health information 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 for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of chiropractic students.

  For example, we may disclose your protected health information to chiropractic interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We "Do - Do Not" have open therapy/adjusting areas.

  We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

  We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

- *Disclosures of psychotherapy notes*
- *Uses and disclosures of Protected Health Information for marketing purposes;*
- *Disclosures that constitute a sale of Protected Health Information;*
- *Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.*

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

- **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 et. seq.

B. Your Rights

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

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

  Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied 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. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.

- **You have the right to request a 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 have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office.* 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 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. *You may opt out of fundraising communications in which our office participates.*

  Your provider is not required to agree to a restriction that you may request. If the doctor 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. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

  You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

- You may have the right to have your doctor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set 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. Please contact our Privacy Officer if you have questions about amending your medical record.

- You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. 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, 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. The right to receive this information is subject to certain exceptions, restrictions and limits.

- ***You have the right to be notified by our office of any breech of privacy of your Protected Health Information.***

- **Certain treatments may be performed in a common therapy area and/ or you may find yourself within public areas within the clinic times, but please note private rooms are always available, upon request, for discussing your private health information.**

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 electronically.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. *To file a complaint you may go to:*

http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf

Or our office can provide you with a written form in which to file your complaint. You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Kimberly L Poynor. You may contact our Privacy Officer or any staff member, including Judith Shafer, at the following phone number: 610-837-8854 or on our website: www.drbackinaction.com for further information about the complaint process.

This notice was published and becomes effective on January 1, 2017