Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date:_____

Name:_____ Date of Birth:_____
Address:_____ City:_____ State:_____ Zip:_____
Mailing Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone: _____
Cell Phone: _____ email address: _____
Social Security #:_____ Age:_____ ❑ Male ❑ Female
Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Other _____
Name of Spouse or Nearest Relative:_____ Phone:_____
Your Occupation_____ Your Employer:_____
Referred to this Office by: ❑Friend/Family Member - Name?_____
❑Yellow Pages ❑ Mail ❑Clinic Location ❑Other_____
Payment for Services will be by: ❑Cash ❑Check ❑Credit Card ❑Health Insurance
❑Automobile Insurance ❑Worker's Compensation
Name of Insurance Co.:_____ Insured's Employer: _____
Insured's Social Security #:_____ Employer's Phone #:_____
Are you covered by more than one insurance company? ❑Yes ❑No Name _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your symptoms(1-10, with 1 being least serious)

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

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT ❑Constant
WHEN AND HOW OCCURRED?_____

_____

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT
❑ILLNESS -❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED:_____
SYMPTOMS HAVE PERSISTED FOR # ____HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)
SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING
PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING
HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES WHEN?_____
NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition_____ Date of Last Physical Exam_____

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:

❑blurred vision	❑constipation	❑fever	❑loss of smell
❑buzzing in ears	❑depression	❑fatigue	❑low resistance to colds
❑cold feet	❑diarrhea	❑head seems too heavy	
❑cold hands	❑dizziness	❑headaches	❑muscle jerking
❑cold sweats	❑face flushed	❑insomnia	❑numbness in fingers
❑concentration loss /confusion	❑fainting	❑light bothers eyes	❑numbness in toes
	❑loss of balance	❑loss of taste	❑pins and needles in arms
❑shortness of breath	❑stiff neck	❑stomach upset	❑pins and needles in legs
❑ringing in ears			

SURGICAL HISTORY:

1._____ Date:_____
2._____ Date:_____
3._____ Date:_____

ACCIDENT HISTORY : ❑Job ❑Auto ❑Other 1._____Date:_____
❑Job ❑Auto ❑Other 2._____Date:_____
❑Job ❑Auto ❑Other 3._____Date:_____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	Stroke
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	tuberculosis
								❑	❑	❑	venereal disease

ARE YOU ALLERGIC TO ANY MEDICATIONS ❑NO ❑YES WHAT KIND?_____
ARE YOU TAKING ANY MEDICATIONS ❑NO ❑YES WHAT KIND?_____
ARE YOU PREGNANT ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD_____

Patient's Signature:_____ Date:_____

What's in a number?

How to rate your symptoms, 1-10

10. Your pain is intense, constant, generally restricts your activities, and it is impossible to go more than 5 minutes without awareness of the pain.

9. Same as above, but you can forget about the pain for up to 15 minutes at a time.

8. The pain is significant, moderately intense at times, but constant. Most activities are affected; you think about it once or twice an hour.

7. Same as above, except that the pain is never intense.

6. The pain is moderate, yet too frequent to ignore. Some activities are affected. Hours can go by without being aware of the pain.

5. Same as above, except that the pain is never intense.

4. The pain is little more than a nuisance, and you go through the whole day frequently aware, but never affected by it.

3. Same as above, except that the awareness of the pain may not be for a whole day at a time.

2. At it's worst, the pain is best described as "a little uncomfortable." Days can go by without being aware of it.

1. Same as above, except that the symptom does not occur more frequently than once a week.

PAYMENT/INSURANCE INFORMATION

Please complete all applicable information.

OUR OFFICE POLICY STATES THAT PAYMENT IS DUE WHEN SERVICES ARE RENDERED. AS A COURTESY TO YOU, WE WILL FILE YOUR INSURANCE CLAIMS FOR YOU.

- ☐ **Cash/Check**: Payment is due in full when services are rendered.
- ☐ **Insurance:** We will file your medical insurance for you. Deductible amounts and co-payment amounts are due in full as services are rendered. Any charges not covered by the insurance company will be billed directly to you for payment.
- ☐ **Automobile Insurance**: We must have verification of insurance, a copy of your insurance card, and the accident report. Any charges not covered by the insurance company will be billed directly to you for payment.
- ☐ **Workers compensation**: Authorization for treatment must be in writing from your employer. If this is not possible on the first visit we will accept verbal authorization until authorization can be obtained in writing.
- ☐ **Medicare**: We must have a copy of your Medicare card or verification of coverage.

Insurance Information:

Insured Full Name _____ Insured Date of Birth ___/___/___
Relationship to the Insured _____ Home phone ( ) _____
Insured SS# _____
Insurance Company Name _____
Ins Co Phone Number ( ) _____ Group # _____
Insured Employer _____ Phone number ( ) _____

I _____, have read the above and checked one method of payment. I have agreed that the balance is my responsibility and will pay any balance that has gone unpaid over 60 days.

Patient Signature _____
Witness _____
Date _____

Health Care Authorization Form

Patient's Name: _____

Patient's SSN: _____ **Date of Birth:** _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **Dr. Cynthia L. Mignano and/or Dr. Salvatore Mignano** TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to Dr. Cynthia L. Mignano and/or Dr. Salvatore Mignano to use my clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.

- I give Dr. Cynthia L. Mignano and/or Dr. Salvatore Mignano to use my name and clinical records for testimonials.

- By signing this form you are giving Dr. Cynthia L. Mignano and/or Dr. Salvatore Mignano permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire on the following date: _____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Dr. Cynthia L. Mignano and/or Dr. Salvatore Mignano. The written notice must contain the following information:

-Your name. Social Security number and date of birth
-A clear statement of our intent to revoke this AUTHORIZATION
-The date of your request
-Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Dr. Cynthia L. Mignano and/or Dr. Salvatore Mignano for its own use/disclosure of PHI. (Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Dr. Cynthia Mignano and/or Dr. Salvatore Mignano will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be use/disclosed.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU

Print Name of Patient: _____

Signature of Patient: _____

Date: _____

Signature of Personal Representative: _____

Description of Representative's Authority to Act for Patient: _____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

_____ _____

Patient Signature Date

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

I. Uses and Disclosures

B. We may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes.

Treatment. *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations. *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

C. We may use or disclose your protected health information without your written consent, written authorization or oral agreement under the following circumstances:

If we provide services to you while you are an inmate.

If we provide services to you in an emergency treatment situation.

If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.

If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend for us to treat you.

If we need to notify, or assist in the notification of, a family member, personal representative or another person responsible for your care of your location, general condition or death.

If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.

If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.

If we are required to disclose your health information to the Food and Drug Administration.

If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness.

If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect or domestic violence.

If we are required to disclose your health information to a health oversight agency for oversight activities required by law.

If we are required to disclose your health information in response to a court order or a subpoena.

If we are required to disclose your health information to a law enforcement official.

If we are required to disclose your health information to a coroner, medical examiner or funeral director.

For research purposes.

If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.

If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illnesses.

WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OR DISCLOSURE OF YOUR HEATH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED, IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION.

II. Your Rights

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official.

Right to Receive Confidential Communications. You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our Privacy Official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

Right to Inspect and/or Copy. You have the right to inspect and/or copy certain health information for as long as that information remains in your record. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.

Right to Receive an Accounting. You have the right to receive an accounting of our disclosures of your health information made six years prior to the date of your request. We will provide you with the first accounting in any 12 month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to our Privacy Official. The accounting will not include the following disclosures:

Disclosures made to carry out treatment, payment and health care operations;
Disclosures made to you;
Disclosures made in our facility directory;

Disclosures made to individuals involved with your care;
Disclosures made for national security or intelligence purposes;
Disclosures made to correctional institutions or law enforcement officials; and
Disclosures made prior to the compliance date of the HIPPA Privacy Rule.

Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request.

III. Our Duties

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

We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

IV. Complaints

You may complain to us and the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address that follows. We will not take any action against you for filing a complaint.

V. How to Contact Us

If you would like further information about our privacy practices, please contact:

Dr. Cynthia L. Mignano
Mignano Family Chiropractic Center
914 C Folly Road
Charleston, SC 29412
(843) 762-2386 - Telephone
(843) 795-9871 - Fax

EFFECTIVE DATE OF NOTICE: April 20, 2003