Springfield Chiropractic Clinic **Rodney J. Wachter, D.C.**

PATIENT INFORMATION

Today's Date _____ CHART# _____

PATIENT NAME _____ **What do you prefer to be called?** _____

Birthdate: _____ Age: _____ SSN: _____ ☐ Male ☐ Female

STATUS: ☐ Student ☐Single ☐ Married ☐ Divorced ☐ Widowed **Spouse's Name:** _____

Do you have children? ☐ YES ☐ NO How many? _____ Girls/Ages _____ Boys/Ages _____

Mailing Address: _____ Home Phone: _____

_____ Cell Phone: _____

City State Zip

E-Mail Address: _____ Would you like e-mail apt reminders? YES NO

Who is your medical doctor? _____ M.D.'s Phone #: _____

In the event of an emergency, whom should we contact? _____ Relation _____

Home/Cell Phone# _____ Work Phone# _____

EMPLOYMENT INFORMATION

Employer _____ How long? _____

Employer's Address _____ Work Phone# _____

_____

City State Zip

INSURANCE INFORMATION

Primary Insurance

Insurance Company Name _____

Insured's Name _____ Employer: _____

Insured's Date of Birth _____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance

Insurance Company Name _____

Insured's Name _____ Employer: _____

Insured's Date of Birth _____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Person Ultimately Responsible for Account

Name _____ Relation _____

Address _____ Phone#: _____

Authorization, Assignment of Benefits, Insurance and Payment Policy

In consideration of your undertaking to treat me, I agree to the following:

Authorization to Treat

I, the undersigned, hereby authorize this Springfield Chiropractic Clinic, Rodney J. Wachter, D.C., (and whomever may be designated as assistants) to administer such examinations and treatment as they deem necessary.

Assignment of Benefits

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to Rodney J. Wachter, D.C. I hereby authorize assignment of my insurance rights and benefits directly to Rodney J. Wachter, D.C. for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Insurance Policy

Your insurance policy is a contract between you and the insurance company. As a courtesy we accept many plans in the Robertson County and Middle Tennessee area. We work with your primary care physician to obtain the maximum insurance benefits for you. However, even with referrals, the insurance company may choose to deny payment for services rendered. In that event, the patient is responsible for all treatment charges incurred.

Co-Payments, Deductibles, Co-Insurances and non-covered services are collected at the time of service.

Unfortunately, we are unable to determine the exact amount your insurance company will reimburse until they send us an Explanation of Benefits. Therefore, any amount paid at the time of service is an estimation of charges and may need to be increased or decreased after we receive correspondence from your insurance company. I understand that I am responsible for any charges unpaid by my insurance company. EFFECTIVE January 1, 2009: Many insurance policies are no longer paying the exam and re-exam fees. This office will try to contact your insurance company and make you aware of any non-payment at the time of your visit.

Payment

Our policy requires payment in full for all services rendered at the time of visit unless insurance is filed on your behalf (co-payments and deductibles will then be collected at time of service). If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, and any other expenses incurred in collecting your account. All accounts over 90 days may be subject to an interest fee of 1.5% per month – 18% annually. Delinquent accounts are placed with a collection agency who will then report the debt to the three major credit bureaus.

Date	Patient Name (printed)	Patient Signature

Date	Witness

Springfield Chiropractic Clinic **Rodney J. Wachter, D.C.**

Patient Name _____ **Date of Birth**_____ **Today's Date**_____ **Chart#**_____

Referring Physician _____ Phone Number: _____

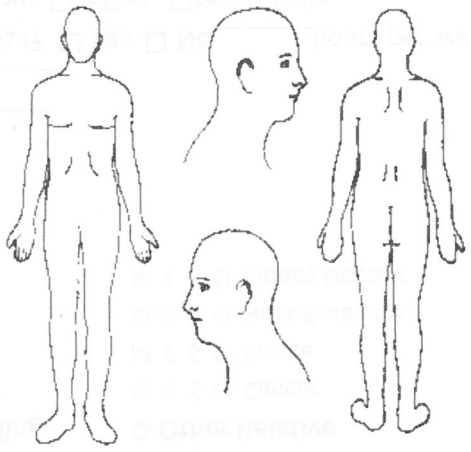
Have you seen a chiropractor in the past? ☐ Yes ☐ No If yes, whom? _____

Medical Doctor's Name _____ Phone _____ Date of last visit _____

Reason for today's visit: ☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness ☐ Auto Accident ☐ Work Accident

1. Describe your symptoms _____
   a. When did your symptoms start? _____
   b. How did your symptoms begin? _____
2. How often do you experience your symptoms?
   ☐ Constantly (76-100% of the day)
   ☐ Frequently (51-75% of the day)
   ☐ Occasionally (26-50% of the day)
   ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms.



3. What describes the nature of your symptoms.
   ☐ Sharp ☐ Shooting
   ☐ Dull ache ☐ Burning
   ☐ Numb ☐ Tingling
   ☐ Other _____
4. How are your symptoms changing?
   ☐ Getting Better
   ☐ Not Changing
   ☐ Getting Worse
5. Describe the intensity of your pain: ☐ Mild ☐ Moderate ☐ Severe
6. During this episode, how much has pain interefered with your normal work (Including both work outside the home and housework)?
   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
7. In general how would you describe your overall health at this time:
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
8. Who have you seen for your symptoms? ☐ No one ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist
   a. What treatment did you receive and when? _____
   b. What tests have you had for your symptoms and when were they performed?
      ☐ X-rays date: _____ ☐ MRI date: _____
      ☐ CT Scan date: _____ ☐ Other date: _____
9. Have you had similar symptoms in the past? ☐ Yes ☐ No
   a. If you had treatment for similar symptoms in the past, who did you see?
      ☐ This office ☐ Other Chiropractor ☐ Medical Doctor ☐ Physical Therapist
   b. What treatment did you receive and when? _____
10. At present are you being treated for any other medical conditions, and what diagnostic tests have been performed in the last twelve months? _____
11. What is your current work status? ☐ Full-time ☐ Part Time ☐ Self-Employed ☐ Unemployed ☐ Off Work ☐ Other
    a. Who is your employer? _____
    b. What is your occupation/ job duties? _____

Springfield Chiropractic Clinic **Rodney J. Wachter, D.C.**

Patient Name _____ Today's Date _____ Chart# _____

Please list past diseases/illnesses: _____

Please list past surgeries with dates: _____

Major falls or accidents: _____

Automobile accidents: _____

Allergies to medications: _____

1. **Are you taking any of the following medications?**
   ☐ Nerve Pills ☐ Pain killers (including aspirin) ☐ Muscle Relaxers ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin
   Please list any other medications you are taking: _____
2. **Do you have or have had any of the following diseases, medical conditions or procedures?**

Y N Heart Attack/Stroke	Y N Heart Surgery/Pacemaker	Y N Heart Murmur	Y N Mitral Valve Prolapse
Y N Congenital Heart Defect	Y N Artifical Valves	Y N Hepatitis	Y N Shingles
Y N Frequent Neck Pain	Y N Psychiatric Problems	Y N Ulcers/Colitis	Y N Glaucoma
Y N Severe Frequent Headaches	Y N Fainting/Seizures/Epilepsy	Y N Anemia	Y N Cancer
Y N Lower Back Problems	Y N Difficulty Breathing	Y N Rhuematic Fever	Y N Chemotherapy
Y N Artifical Bones/Joints	Y N Tuberculosis	Y N Arthritis	Y N Alcohol/Drug Abuse
Y N High/Low Blood Pressure	Y N Emphysema/Asthma	Y N Sinus Problems	Y N HIV+/AIDS/ARC
Y N Diabetes/Hypoglycemic	Y N Veneral Disease	Y N Kidney Problems	

3. **Family History**

Circle all that apply	M-Mother F-Father	S-Sibling	O-Other Relative
M F S O Heart Disease	M F S O Thyroid Disease		M F S O Cancer
M F S O Diabetes	M F S O High Blood Pressure		M F S O Stroke
M F S O Low Back Problems	M F S O Chronic Headaches		M F S O Neck Problems
M F S O Scoliosis	M F S O Sinus Problems		M F S O Kidney Disease
M F S O Arthritis	M F S O Asthma/Other lung condition		

   M F S O Other: _____
   ☐ Father living/good health ☐ Mother living/good health
   ☐ Parent(s) deceased Father/Age: _____ Cause: _____
   Mother/Age: _____ Cause: _____
4. Do you take supplements or vitamins? ☐ Yes ☐ No Do you exercise? ☐ Yes ☐ No _____hours per week
5. Do you drink caffeinated beverages? ☐ Yes ☐ No _____ cups/day: ☐coffee ☐tea ☐cola
6. Do you smoke? ☐No ☐Yes How much? _____ How long? _____
7. Do you drink? ☐No ☐Socially ☐Daily ☐Rarely
8. Are you wearing: ☐Shoe lifts ☐Inner Soles ☐Arch Supports Are you dieting? ☐No ☐Yes Since __/__/____

FOR WOMEN: ARE YOU TAKING BIRTH CONTROL? ☐Yes ☐No DLMP _____
Are you nursing? ☐Yes ☐No Are you pregnant? ☐No ☐Yes If so, how many weeks? _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Date	Printed Patient Name	Patient Signature
Date	Name of person completing form if not completed by patient	Relationship to Patient

SPRINGFIELD CHIROPRACTIC CLINIC
2208 Memorial Blvd., Springfield, TN 37172

BACK INDEX

RODNEY J. WACHTER, D.C.

PATIENT NAME: _____ DATE: _____ CHART# _____

This questionnaire will give the doctor information about how your back condition affects your everyday life. Please answer every section by circling ONE statement that best applies to you.

Mark your answer according to this scale: 1. It's there and I can do it no matter what
2. I know It's there – it bugs me, and I can still do it
3. I'm hurting – I can do it, but I would rather not
4. Hurts pretty bad, but I can still try to do it
5. I don't want to do it – it hurts too bad

PAIN INTENSITY

0 The pain/discomfort comes and goes and is very mild
1 The pain/discomfort is mild and does not vary much

2 The pain/discomfort comes and goes and is moderate
3 The pain/discomfort is moderate and does not vary much
4 The pain comes and goes and is severe

5 The pain is sever and does not vary much

PERSONAL CARE

0 I can look after myself without causing extra pain/discomfort
1 I can look after myself but it gives me extra pain/discomfort

2 It is painful to look after myself and I am slow and careful

3 I need some help but I manage most of my personal care
4 I need help every day in most aspects of self care
5 Because of the pain, I am unable to do any washing and Dressing without help, and I stay in bed

LIFTING

0 I can lift heavy weights without extra pain/discomfort
1 I can lift heavy weights but it causes extra pain/discomfort
2 Pain prevents me from lifting heavy weights off floor
3 Pain prevents me from lifting heavy weights of floor , but I can manage if they are conveniently positioned on table
4 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if conveniently positioned
5 I can only lift light weights at the most

WALKING

0 I have no pain/discomfort on walking
1 I have some pain walking, but it does not increase with distance
2 I cannot walk more than 1 mile without increasing pain
3 I cannot walk more than ½ mile without increasing pain
4 I cannot walk more than ¼ mile without increasing pain
5 I cannot walk at all without increasing pain

SITTING

0 I can sit in any chair as long as I like
1 I can sit in my favorite chair as long as I like
2 Pain prevents me from sitting more than 1 hour
3 Pain prevents me from sitting more than ½ hour
4 Pain prevents me from sitting more than 10 minutes
5 I avoid sitting because it increases pain immediately

INDEX SCORE _____

STANDING

0 I can stand as long as I want without pain/discomfort
1 I have some pain while standing but it does not increase with time
2 I can't stand for more than 1 hour without increasing pain
3 I can't stand for longer than ½ hour without increasing pain
4 I can't stand for longer than 10 minutes without increasing Pain
5 I avoid standing because it increases pain immediately

SLEEPING

0 I get no pain/discomfort in bed
1 I get pain/discomfort in bed, but it doesn't prevent me from sleeping well
2 Because of pain, my normal night's sleep is reduced ¼ and can wake me up.
3 Because of pain, my normal night's sleep is reduced by ½
4 Because of pain, my normal night's sleep is reduced by ¾
5 Pain prevents me from sleeping at all

SOCIAL LIFE/HOBBIES/RECREATION

0 My social life is normal and gives me no pain/discomfort
1 My social life is normal but increases the degree of pain
2 Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing
3 Pain has restricted my social life and I do not go out very often
4 Pain has restricted my social life to my home
5 I have hardly any social life because of the pain

TRAVEL/DRIVING

0 I get no pain/discomfort while traveling/driving
1 I get some pain while traveling/driving, but none of my usual forms of travel/driving make it any worse
2 I get pain/discomfort while traveling/driving but it does not compel me to seek alternative forms of travel
3 I get extra pain while traveling, which compels me to seek alternative forms of travel
4 Pain restricts all forms of travel
5 Pain prevents all forms of travel except that done lying down

CHANGING DEGREE OF PAIN

0 My pain/discomfort is rapidly getting better
1 My pain/discomfort fluctuates, but overall is getting better
2 May pain seems to be getter better, but is slow
3 My pain is neither getting better nor worse
4 My pain is gradually worsening
5 My pain is rapidly worsening

SPRINGFIELD CHIROPRACTIC CLINIC
2208 Memorial Blvd., Springfield, TN 37172

NECK INDEX

RODNEY J. WACHTER, D.C.

PATIENT NAME: _____ DATE: _____ CHART# _____

This questionnaire will give the doctor information about how your neck condition affects your everyday life. Please answer every section by circling ONE statement that best applies to you.

Mark your answer according to this scale:

1. It's there and I can do it no matter what
2. I know it's there – it bugs me, and I can still do it
3. I'm hurting – I can do it, but I would rather not
4. Hurts pretty bad, but I can still try to do it
5. I don't want to do it – it hurts too bad

PAIN INTENSITY

0 The pain/discomfort comes and goes and is very mild
1 The pain/discomfort is mild and does not vary much
2 The pain/discomfort comes and goes and is moderate
3 The pain/discomfort is moderate and does not vary much
4 The pain comes and goes and is severe
5 The pain is very severe and does not vary much

CONCENTRATION

0 I can concentrate fully without difficulty
1 I can concentrate fully with slight difficulty
2 I have a fair degree of difficulty concentrating
3 I have a lot of difficulty concentrating
4 I have a great deal of difficulty concentrating
5 I can't concentrate at all

PERSONAL CARE

0 I can look after myself normally without causing extra pain
1 I can look after myself but it causes extra pain/discomfort
2 It is painful to look after myself and I am slow and careful
3 I need some help but I manage most of my personal care
4 I need help every day in most aspects of self care
5 Because of the pain I am unable to do any washing & dressing without help and I stay in bed

SLEEPING

0 I have no trouble sleeping
1 My sleep is slightly disturbed for less than 1 hour
2 My sleep is mildly disturbed for up to 1-2 hours
3 My sleep is moderately disturbed for up to 2-3 hours
4 My sleep is greatly disturbed for up to 3-5 hours
5 My sleep is completely disturbed for up to 5-7 hours

LIFTING, i.e. GROCERIES,CHILDREN,ETC

0 I can lift heavy weights without causing extra pain/discomfort
1 I can lift heavy weights but it causes extra pain/discomfort
2 Pain prevents me from lifting heavy weights off the floor
3 Pain prevents me from lifting heavy weights off floor, but I Can manage if they are conveniently positioned on table
4 I can only lift very light weights at most
5 I cannot lift or carry anything at all

DRIVING OR RIDING AS A PASSENGER

0 I can drive my car without neck pain or discomfort
1 I can drive as long as I want with slight pain/discomfort
2 I can drive as long as I want with moderate pain/discomfort
3 I can't drive as long as I want because of moderate neck pain
4 I can hardly drive at all because of sever neck pain
5 I can't drive my car at all because of neck pain

WORK – INCLUDE HOUSEWORK AND YARDWORK

0 I can do as much work as I want
1 I can do my usual work, but no more
2 I can do most of my usual work but with difficulty
3 I can't do my usual work
4 I can't hardly do any work at all
5 I can't do any work at all

READING/COMPUTER WORK

0 I can read as much as I want with little/no pain/discomfort
1 I can read as much as I want with slight neck pain
2 I can read as much as I want with moderate pain
3 I can't read as much as I want because of moderate pain
4 I can't read as much as I want because of severe pain
5 I can't read/computer work at all

HEADACHES

0 I have not headaches at all
1 I have slight headaches that come infrequently
2 I have moderate headaches that come infrequently
3 I have moderate headaches that come frequently
4 I have severe headaches that come frequently
5 I have headaches almost all the time

RECREATION/HOBBIES

0 I have no neck pain during all recreational activities
1 I have some neck pain with all recreational activities
2 I have some neck pain with a few recreational activities
3 I have neck pain with most recreational activities
4 I can hardly do any recreational activities due to neck pain
5 I can't do any recreational activities due to neck pain.

INDEX SCORE _____

Springfield Chiropractic Clinic
2208 Memorial Blvd., Springfield, TN 37172

Rodney J. Wachter, D.C.
Phone: 615-384-4000

Consent to Chiropractic Examination and Treatment

Chiropractic is a health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. The primary treatment provided by Doctors of Chiropractic is spinal manipulative therapy, also referred to as an adjustment. A Doctor of Chiropractic uses his/her hands and/or a mechanical instrument on the patient's body in such a way as to move the patient's joints. This may cause an audible "pop" or "click" such as when a person "cracks" his knuckles. The patient may feel a sense of movement as well.

Other procedures commonly used by Doctors of Chiropractic include the following:

Physical Examination	Postural Analysis	Vital Signs	Traction/Decompression	Palpation
Bracing and Support Applications	Ultrasound Therapy	Hot/Cold Therapy	Electrical Muscle Stimulation	
Diagnostic Studies	Manual Therapy	Laser Therapy	Rehabilitation	

The material risks associated with chiropractic treatment

Initials _____ Chiropractic treatment utilizes very safe, non-invasive procedures performed in chiropractic offices to reduce pain, restore range of motion, and promote overall body wellness, among other various benefits. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Possible complications include but are not limited to the following: muscle strain, dizziness, nausea, flushing, fractures, disc injuries, dislocations, cervical myelopathy, burns, costovertebral strains and separations. It is not uncommon for patients to experience temporary soreness after the first few treatments. In rare cases, manipulation of the neck has been associated with injuries to the arteries of the neck, leading to or contributing to serious complications, including stroke. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Initials _____ Fractures are rare occurrences and generally result from underlying weakness of the bone for which the Doctor of Chiropractic checks during the taking of the patient's history, and during examination and x-ray. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options may include the following

Initials _____ Self administered, over-the-counter analgesics and rest
Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers
Hospitalization/Surgery

There are risks and benefits associated with all the above treatment options, which the patient may wish to discuss with his/her medical doctor.

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Failure to seek care could result in serious medical conditions going unrecognized. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that **Rodney J. Wachter, D.C.** will advise me of any material risks in this regard.
2. Neither the practice of chiropractic nor the practice of medicine is an exact science, and my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. It is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, and an undesirable result does not necessarily indicate an error in judgment or treatment.
4. Dr. Wachter does not guarantee any results with respect to any course of care or treatment.

DO NOT SIGN UNTIL YOU HAVE READ ABOVE AND UNDERSTAND THE ABOVE. ONCE READ AND UNDERSTOOD, PLEASE CHECK THE APPROPRIATE BLOCK IN THE PARAGRAPH AND BELOW AND SIGN.

PATIENT:

I ( ) have read, or ( ) have had read to me, the above explanation of chiropractic adjustment and related treatment. I hereby authorize **Dr. Rodney J. Wachter** and his assistants, associates and other appropriate persons to render care, to perform an examination and to provide an appropriate evaluation and treatment plan to address the complaints, problems, and medical history I have provided. I have discussed any questions, comments, or concerns with Dr. Wachter and have had my inquiries answered to my satisfaction. By signing below, I state that I have weighed the risks and/or benefits in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____

Patient Name | Patient Signature (Parent or Guardian if a minor)

_____ _____

Date | Witness

Patient Name _____ Chart#_____ Date_____

ATTENTION PATIENT!

DO NOT SIGN THIS FORM UNTIL YOU HAVE SPOKEN WITH THE DOCTOR.

PATIENT STATUS AT TIME OF INFORMED CONSENT PROCESS

Based on my personal observations, medical history, and direct conversation with the patient, I conclude that throughout the consent process the patient was:

- ☐ Of legal age
- ☐ Oriented x3
- ☐ Disoriented as to _____
- ☐ Coherent and lucid
- ☐ On prescription/OTC medications but unimpaired
- ☐ Proficient in understanding English language
- ☐ Assisted in understanding by an interpreter
  Interpreter's Name: _____
- ☐ Resolute in denying the use of alcohol and/or recreational drugs prior to consent
- ☐ Unable to give legal consent _____
  Patient Representative
- ☐ Consent given through legal guardian _____
  Relationship to Patient

Patient's questions (if any) and information supplied are as follows:

_____

_____

_____

Comments: _____

I certify that the above accurately describes the above named patient's status during the informed consent, and that he/she understands the explanation of chiropractic adjustment and related treatment.

I _____ have been given an opportunity to ask questions regarding my care.

_____ _____

Patient Signature Date

_____ _____

Rodney J. Wachter, D.C. Date

Springfield Chiropractic Clinic | Rodney J. Wachter, D.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINAINTED FOR SIX YEARS.

Home Telephone# _____

☐ Leave message with call back information *ONLY.*

☐ Okay to leave detailed message.

☐ Do not leave message at this number.

Work Telephone# _____

☐ Leave message with call back information *ONLY.*

☐ Okay to leave detailed message.

☐ Do not leave message at this number.

Cell Telephone# _____

☐ Leave message with call back information *ONLY.*

☐ Okay to leave detailed message.

☐ Do not leave message at this number.

DISCLOSING YOUR HEATLH INFORMATION TO OTHER INDIVIDUALS:

☐ Do not release any information to anyone except me. (This includes your spouse, parents, etc.)

☐ You have my permission to disclose information to the following person(s):

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Patient Name (Please Print) Date

_____ _____

Patient Signature or Parent/Guardian if Minor Witness

I _____ have been given a complete copy of the "Notice of Privacy Practices" from Springfield Chiropractic Clinic.

Springfield Chiropractic Clinic

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION

PLEASE REVIEW CAREFULLY

This Practice is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. Some or part of your PHI may be overheard in this office. Dr. Wachter and staff will never initiate a conversation with a patient regarding their Private Health Information in an open area.

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

The Practice may use and/or disclose your PHI for the purpose of:

Treatment, Payment, Health Care Operations, Emergency Situations, Abuse, Neglect or Domestic Violence, Worker's Compensation.

APPOINTMENT REMINDER

The Practice, may from time to time contact you to provide appointment reminders.

YOUR RIGHTS

You have the right to request a full copy of the "Notice of Privacy Practices"

You have specific rights as listed in the "Notice of Privacy Practices"

PRACTICE'S REQUIREMENTS

This Practice:

- ✓ Is required to abide by the terms of the Privacy Notice
- ✓ Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective by 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.
- ✓ Is required by federal law to inform you that information sent from this office via FAX or E-MAIL IS NOT ENCRYPTED. Patient Initials _____ Witness _____
- ✓ This office sends e-mail reminders upon request. Any e-mail other than your personal e-mail address (i.e. corporate/family, etc.) has the potential of being viewed by others. Patient Initials _____ Witness _____

Springfield
Chiropractic Clinic
The power that made the body, heals the body.

Dr. Rodney J. Wachter
Chiropractic Physician

Ph: 615.384.4000 • Fx: 615.384.4487 **www.spfdchiropractic.com** **2208 Memorial Blvd. • Springfield, TN 37172**

ATTENTION PATIENTS:

A complete copy of the HIPAA Privacy Law is available under the "Privacy Policy Statement" tab.
Or, if you prefer, you may request a copy at your appointment.

Thank you!

Springfield Chiropractic Clinic

Springfield Chiropractic Clinic

Rodney J. Wachter, D.C.

Patient Name: _____ Date of Birth: _____ Chart#_____

Are you currently taking any prescribed medications? _____Yes _____No

Prescribed Medications

Medication	# of Refills	Quantity of Pills	Strength	Dose Form	What is this for?

Are you allergic to any medications? _____Yes _____No

Please list each drug to which you have an allergic reaction to on a separate line.

Name of Drug	Allergic Reaction

_____ _____

Patient Signature Date

Springfield Chiropractic Clinic
Rodney J. Wachter, D.C.

U.S. Government Certification Data

Dear Patient:

The U.S. Government is now requiring that we supply them with the following information. We appreciate your help as we update patient records.

Please print all information

Name_____ Today's Date _____

Date of Birth_____

Ethnicity: (Please circle)

Hispanic or Latino Non-Hispanic or Latino

Race: (Please circle)

White American Indian/Native Asian Black/African American
Native Hawaiian/Pacific Islander Two or More

Preferred Language: (Please circle)

English Spanish French German Italian
Mandarin Cantonese Tagalong Japanese Other _____

If we need to contact you, how would you like the confidential information to be received?

Home phone: _____ Work Phone: _____
Cell phone: _____
E-Mail: _____
Mailing address: _____

Smoking Status: (Please circle)

Smokes every day Smokes some days Former Smoker Never Smoked

Have you been diagnosed with: (Circle all applicable)

Asthma Diabetes Hypertension/Blood Pressure Problems

Are you taking medication for: _____High Blood Pressure _____Diabetes _____Asthma

Have you had any change of medications since your last update/visit to this office? _____Yes _____No

Are you taking the flu shot for the current season? ____Yes ____No ____I am not planning on taking the flu shot.