

Confidential Patient Health Record

Date:

I.D. Number

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ State/Prov: _____ Zip/Postal Code: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: M F

Cell Phone: _____ E-mail Address: _____

Social Security # _____ Driver's License #: _____

Business Employer: _____ Circle One: Married Single Widowed Divorced Separated

Type of Work: _____ Business Phone: _____

Name of Spouse: _____ Spouse's Social Security #: _____

Spouse's Employer: _____ Business Phone: _____

Type of Work: _____ Name and ages of children _____

Referred to this office by: _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who is responsible for your bill, You and Spouse Worker's Comp. Auto Insurance Medicare Medicaid

Personal Health Insurance (Name): _____ Health Card #: _____

Insured Person's Name: _____ Date of Birth: _____

CURRENT HEALTH CONDITION

Unwanted Health Condition: _____

Other doctors seen for this condition: Yes No ___ Who? _____

Type of Treatment: _____ Results: _____

When did this condition begin? _____ Has this condition occurred before? Yes No

Is condition: Job Related Auto Accident Home Injury Fall Other: _____

Date of Accident: _____ Time of Accident: _____

Have you made a report of your accident to your employer? Yes No

Drugs You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine

Insulin Other: _____

Do you wear a shoe lift? Yes No

Do you suffer from any condition other than that which you are now consulting us? _____

PAST HISTORY

Please Check and Describe:

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery

Broken Bones Other: _____

Major Accidents or Falls: _____

Hospitalization (Other than above): _____

Previous Chiropractic Care: None Doctor's name and approximate date of last visit: _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | INTAKE |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema | |

Have you been tested HIV positive Yes No N/A

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS

MUSCULO-SKELETAL CODE

- | | |
|---|---|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Gas/Bloating after Meals |
| <input type="checkbox"/> Pain between Shoulders | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Black/Blood Stool |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Joint Stiffness | |

- | |
|---|
| <input type="checkbox"/> Walking Problems |
| <input type="checkbox"/> Difficult Chewing/
Clicking Jaw |
| <input type="checkbox"/> General Stiffness |

NERVOUS SYSTEM CODE

- | |
|----------------------------------|
| <input type="checkbox"/> Nervous |
|----------------------------------|

GENITO-URINARY CODE

- | |
|--|
| <input type="checkbox"/> Bladder Trouble |
| <input type="checkbox"/> Painful/Excessive Urination |
| <input type="checkbox"/> Discolored Urine |

C-V-R CODE

- | |
|-------------------------------------|
| <input type="checkbox"/> Chest Pain |
|-------------------------------------|

FEMALES ONLY

When was your last period? _____

Are you pregnant? Yes No Not sure

GENERAL CODE

- | |
|--|
| <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Loss of sleep |
| <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches |

EENT CODE

- | |
|---|
| <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Dental Problems |
| <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Ear Aches |
| <input type="checkbox"/> Hearing Difficulty |
| <input type="checkbox"/> Stuffed Nose |

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

FAMILY HISTORY

The following members have the same or similar problem as I do:

- Mother
- Brother
- Spouse
- Father
- Sister
- Child

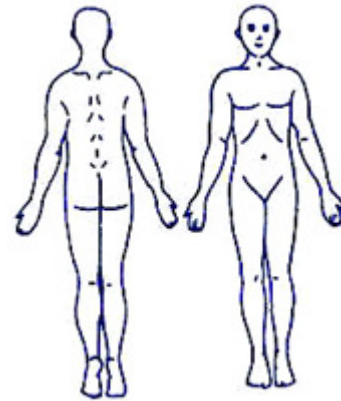
GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____
- _____

Please outline on the diagram the area of your discomfort



Relief Care

Relief Care is that care necessary to get rid of your symptoms of pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come in for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care so that we may be guided by your wishes whenever possible.

Relief Care Corrective Care Check here if you want the Doctor to select the type of care appropriate for your condition.

Patient's Signature: _____ Date: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen anytime while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature: _____ Date: _____

Consent to treat a minor: _____ Date: _____

Guardian or spouse's signature of authorizing care _____ Date: _____

If this is an accident related injury, please fill out the Accident Form. Thank You!

Patient Request for Records

Date: _____

To: _____

I hereby authorize the release of my

_____ Health Records
_____ X-Rays
_____ X- Ray Reports
_____ Lab Reports

or copies of such and request that they be transferred to:

Dr. Desiree Kiehn D'Agostino
651 Boylston Street- suite #2
Boston, MA. 02116

Patient's Name (please print) _____

Date of Birth _____

Date of Records _____

Patient's Signature _____

*This request expires one (1) year from date of signature unless otherwise specified.

Copley Health Alliance
NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of 4.14.03, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. **TREATMENT, PAYMENT, HEALTH CARE OPERATIONS:** You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

B. **AUTHORIZATIONS:** You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

C. **DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

D. **MARKETING:** We will not use your health information for marketing communications without your written authorization.

E. **USES OR DISCLOSURES REQUIRED BY LAW:** We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. **PATIENT AND THIRD PARTY PROTECTION:** Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

G. **LAW ENFORCEMENT/NATIONAL SECURITY:** Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

H. **APPOINTMENT REMINDERS:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

A. **ACCESS TO RECORDS:** Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we will charge you \$.25 for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

B. **ACCOUNTING OF CERTAIN DISCLOSURES.** Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

C. **RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS:** You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

D. **AMENDMENTS TO RECORDS:** You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. **ELECTRONIC NOTICES.** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information

listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

Contact: Dr. Desiree Kiehn

Telephone: (617) 859-9500

Fax: (617) 859-9595

E-mail: drdagostino@eback.com

Address: 651 Boylston St. Suite #2; Boston, MA 02116

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**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I, _____, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Copley Health Alliance, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Date

Signature

Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- Patient Unavailable
 Patient Physically Unable
 Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply) :

- Personally Mail Phone Follow Up
 Other: _____

Date

Signature

Print Name of Physician

Copley Health Alliance
Name of Practice

Copley Health Alliance
Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ [Name of Individual] consent to Copley Health Alliance's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Late Cancellation/Missed Appointment Policy

If you are not able to keep a scheduled appointment, we ask that you give us 24 hours notice (by Saturday Noon, for Monday appointments). This allows us the office to run more smoothly and facilitates our being able to care for all our patients.

If you cancel an appointment within 24 hours or if you miss a scheduled appointment, a \$45.00 charge will be applied to your account. You are also expected to make up a missed appointment so you can follow your treatment schedule.

NOTE: Insurance Companies will not pay for missed appointments. You are responsible for this fee.

Please sign below:

I understand that I will be held responsible for any late cancellations (less than 24 hours) or missed appointments and I will pay a \$45.00 charge for each.

Signature

Date