# YOUTH HEALTH HISTORY

Name_____________________________ Sex: Male Female Date______________

Address___________________ City__________________ State______ Zip________

Home Phone:____________________ Age_______ Birthdate___________________

School and Grade:__________________ Preferred Language? (Optional)______________

Race (Optional): Asian Black Caucasian (white) Hispanic Native American Other

Parents Name:__________ SSN:___________ Employer:__________ Birthdate:__________

__________ SSN:___________ Employer:__________ Birthdate:__________

Insurance Company:__________________________

Your Medical Doctor______________ City/State Medical Dr. located__________________

Who recommended you to our office?_________________________

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Major complaints and symptoms_______________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

When did you first notice this?_____________________________________________

Any family history of this condition?_______________________________________

Was it caused by an automobile accident?__________________ Injury______________

Have you had treatment by another doctor for this? Yes______________ No______________

Medications you are currently taking:_______________________________________

Vitamins/supplement you are currently taking:_______________________________

Please list any drug allergies: ____________________________________________

**For Children 13 years and Older**

Smoking Status: Current Every Day Smoker Current Some Day Smoker Former Smoker

Never Smoker Smoker, Current Status Unknown Unknown if Ever Smoked

Time Since Quitting: __________ Time Used: __________ Lives with a Smoker? Yes No

Quantity of Tobacco Used?

Chews: ________ Dips: ________ Cigarettes: ________ Cigars: ________ Pipes: ________

Please check any of the following symptoms you have presently:

MUSCULO-SKELETAL SYSTEM

_____ Low back problems
_____ Pain between shoulders
_____ Neck problems
_____ Arm problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Stiff joints
_____ Sore muscles
_____ Weak muscles
_____ Walking problems
_____ Ruptures
_____ Broken bones

GENITO-URINARY SYSTEM

_____ Bladder trouble
_____ Excessive urine
_____ Scanty urination
_____ Painful urination
_____ Discolored urine
_____ Bedwetting

FEMALE

_____ Vaginal discharge
_____ Vaginal bleeding
_____ Vaginal pain
_____ Breast pain
_____ Lumps on breast

Are you pregnant?

_____ Yes _____ No

GASTRO-INTESTINAL SYSTEM

_____ Poor appetite
_____ Excessive hunger
_____ Difficult chewing
_____ Difficult swallowing
_____ Excessive thirst
_____ Nausea
_____ Vomiting food
_____ Vomiting blood
_____ Abdominal pain
_____ Diarrhea
_____ Constipation
_____ Black stool
_____ Bloody stool
_____ Hemorrhoids
_____ Liver trouble
_____ Gall bladder problems
_____ Weight trouble
_____ Colic

NERVOUS SYSTEM

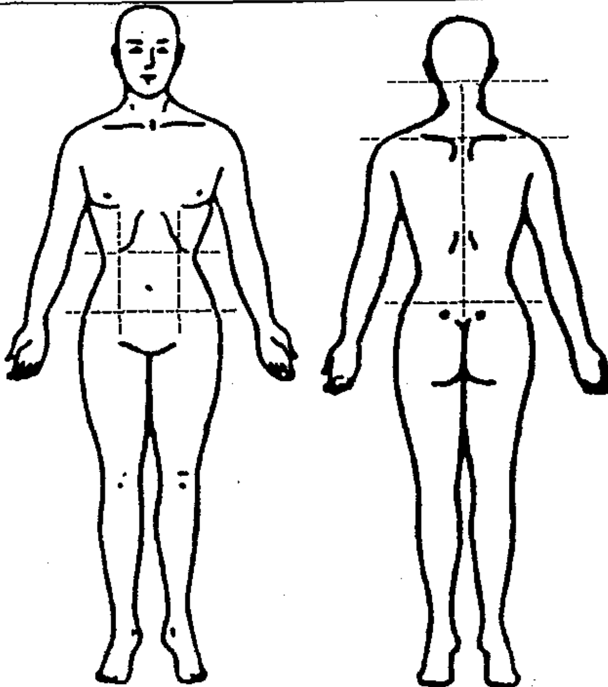
_____ Numbness
_____ Loss of feeling
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Muscle jerking
_____ Convulsions
_____ Forgetfulness
_____ Confusion
_____ Depression

CARDIO-VASCULAR-RESPIRATORY

_____ Chest pain
_____ Pain over heart
_____ Difficult breathing
_____ Persistent cough
_____ Coughing phlegm
_____ Coughing blood
_____ Rapid heartbeat
_____ Blood pressure problems
_____ Heart problems
_____ Lung problems
_____ Varicose veins

EYE, EAR, NOSE AND THROAT

_____ Eye strain
_____ Eye inflammation
_____ Vision problems
_____ Ear pain
_____ Ear noises
_____ Hearing loss
_____ Ear discharge
_____ Nose pain
_____ Nose bleeding
_____ Nose discharge
_____ Difficult breathing thru nose
_____ Sore gums
_____ Dental problems
_____ Sore mouth
_____ Sore throat
_____ Hoarseness
_____ Difficult speech



Date________________________________

________________________________
Parent's Signature

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

**Defiance Chiropractic Center**
1770 Jefferson Avenue
Defiance, OH 43512
419-784-2300

# ASSIGNMENT AND AUTHORIZATION

I hereby authorize and request my accident or health insurance carrier to pay direct to Defiance Chiropractic Center all proceeds payable under the terms of my policy.

I specifically authorize that this assignment may be paid from disability benefits, medical payment or from any benefits due me under this claim. I understand and agree that any unpaid balances not covered by this policy will be paid by me.

I fully understand that I am individually and personally liable for payment to my treating doctor for services rendered.

I authorize Defiance Chiropractic Center to release any information pertinent to my case to any insurance company, adjuster or attorney involved in the case.

| ____________________ | ____________________ |
|---|---|
| Date | Patient signature (Parent/guardian if patient is a minor) |
| | ____________________ |
| | Policy holder signature |

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By subscribing my name below, I acknowledge that I have been given a copy of the Defiance Chiropractic Center's Notice of Privacy Practices.

________________________________________ __________________

Signature Date

**DEFIANCE CHIROPRACTIC CENTER**
1770 Jefferson Avenue
Defiance, Ohio 43512

# 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.**

The Defiance Chiropractic Center, in accordance with the federal Privacy Rule, 45 CFR parts 160 and 164 (the "Privacy Rule") and applicable state law, is committed to maintaining the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Defiance Chiropractic Center and is often referred to as your health care or medical record. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

## Uses and Disclosures

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

Treatment. To provide you with the type of health care you require, we may use and disclose your PHI to those health care professionals, whether on our DCC staff or not, so that it may provide, coordinate, plan and manage your health care. *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. To get paid for services provided to you, we may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including insurance companies and health plans. If necessary, we may use your PHI in other collection efforts with respect to all persons who may be liable to our practice for bills related to your care. *Example:* We may need to provide your insurance program with information about health care services that you received from us so that we may be properly reimbursed. We may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

Health Care Operations. To operate in accordance with applicable law and insurance requirements, and to provide quality and efficient care, we may need to compile, use and disclose your PHI. *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management.

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 in an emergency situation
- ❑ If we provide services to you while you are an inmate
- ❑ 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 intended 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 or other government 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 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 by law 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
- ❑ If we need to disclose your health information to a business associate of our practice. (A business associate is an entity, such as a billing company, that assists our office in submitting claims for payment to insurance companies or other payers.)
- ❑ 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
- ❑ If you are a member of the armed forces, we may disclose your health information as required by the military command authorities

WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OR DISCLOSURE OF YOUR HEALTH 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.

## Advice of Appointment and Services

We may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Defiance Chiropractic Center: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone. Our office may also send a newsletter to your address with this type of information. Please inform us if you wish to be removed from our newsletter mailing list. All newsletters would also include a notice to you on how you may have your name removed from that mailing list. We may also send Welcome or Birthday cards to our patients. Your PHI may be faxed to another provider in situations allowable under HIPAA regulations.

## Family/Friends

We may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your personal health information (PHI) directly relevant to such person's involvement with your care or the payment for your care. However, the following conditions will apply:

- ❑ If you are present at or prior to the use or disclosure of your PHI, we may use or disclose your PHI if you agree, or if we can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure,
- ❑ If you are not present, we will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

## Family Accounts

We will continue to allow family members to be billed on a family account. We do not automatically put anyone on a family account. This is only done upon request from a parent or spouse. You may at any time have a member removed from the famiy account status by contacting our Accounting Department at 419-782-2250.

## 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 Manager.

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 Manager. 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 Manager. Forms are available at the front desk. We may charge a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, we may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

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 Manager and you must provide a reason to support the requested amendment. Forms are available at the front desk. The information to be amended has to have been created by our office (unless the individual or entity that created the information is no longer available). We have the right to deny your request for amendment. If you disagree with a denial, you will have the right to submit a written statement of disagreement.

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, and may not include dates before April 14, 2003. 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 Manager. 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 HIPAA Privacy Rule

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

## 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.

We adhere to Ohio law in those instances where Ohio law does not conflict with federal law. See the explanation of Ohio law, attached.

## Complaints

You may complain to us and to 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 Manager at the address that follows. We will not take any action against you for filing a complaint.

## How to Contact Us

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

Laura Buchholz
Defiance Chiropractic Center
1770 Jefferson Avenue
Defiance, Ohio 43512
Phone: 419-784-2300

## Effective Date

This Notice is in effect as of March 3, 2003. (Revision of Privacy Manager effective September 1, 2004.)

**In accordance with Section 3701.74 of the Ohio Revised Code, you or your representative may request a copy of your medical record.**

A "Medical record" means data in any form that pertains to your medical history, diagnosis, prognosis, or medical condition and that is generated and maintained by the Defiance Chiropractic Center in the process of your health care treatment.

We will provide medical records to your "representative" when you provide written authorization that your representative is authorized to act on your behalf regarding access to your medical records.

If you or your representative wishes to examine or obtain a copy of part or all of a medical record, you must submit a written request, signed by you and dated not more than sixty days before the date on which it is submitted.

You or your representative who wishes to obtain a copy of the record shall indicate in the request whether the copy is to be sent to your residence, your medical physician or another chiropractic physician, or representative, or held for you at our office.

Within 30 days after receiving your request, this office shall permit you to examine the record during regular business hours without charge or, on request, shall provide a copy of the record.

This office shall take reasonable steps to establish the identity of the person making the request to examine or obtain a copy of your record.

In those rare occasions when this office denies a request for you to review your records, it will do so in compliance with applicable state and federal laws, explaining the reason for the denial and your rights as set forth in the Notice of Privacy Practices. You may have a right to bring a civil action to enforce your right to access to your records.

In accordance with Section 3701.741 of the Ohio Revised Code, this office will charge you the following fees for accessing copies of your records:

- One dollar per page for the first ten pages
- Fifty cents per page for pages eleven through fifty
- Twenty cents per page for pages fifty-one and higher
- For data not recorded on paper, the actual cost of making the copy
- The actual cost of any related postage

Copies are provided free to:

- The Bureau of Workers' Compensation
- The Industrial Commission
- The Department of Job and Family Services
- Title II or Title XVI of the "Social Security Act"

Different fees may apply per contract. This section does not apply to copies of medical records provided to insurers.