Dr. John Donovan

Advantage Chiropractic

2 Courthouse Lane, Suite 9, Chelmsford, MA 01824 / 978 . 453 . 0900 / donovanchiropractic.net

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

Printed Name	Authorized Provider Representative
Signature	Date
Date	

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PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF

DR. JOHN DONOVAN

Advantage Chiropractic

2 Courthouse Lane, Suite 9

Chelmsford, MA 01824

Notice of Privacy Practices for Protected Health Information.

Patient Name Printed ______________________ Date ______________________

Patient Signature ______________________ Authorized Provider Rep. ______________________

Personal Representative Printed ______________________ Personal Rep. Signature ______________________

____

Description of personal representative's authority to act for the patient

Dr. John
Donovan

Advantage
Chiropractic

2 Courthouse Lane, Suite 9, Chelmsford, MA 01824 / 978 . 153 . 0900 / donovanchiropractic.net

I authorize my insurance company to make payments directly to:

Dr. John Donovan
Advantage Chiropractic
2 Courthouse Lane
Suite 9
Chelmsford, Ma. 01824

I authorize Dr. John Donovan to release any medical information that may be required to get said claims paid in a timely fashion.

I understand that ultimately I am responsible for payment of any and all unpaid bills for services rendered to me or on my behalf by Dr. John Donovan/Advantage Chiropractic

X____

Appointment Reminders and Health Care Information Authorization

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders/information and understand that…

I may be contacted by: phone at home or work, mobile phone, e-mail, or postcard.
Messages may be left: on answering machine/voicemail at home, work, and on mobile phone.
Or with individuals answering my phone at home, or work.

(Please place a line through any method that you refuse to be contacted by and initial.)

Information that we use or disclose based on this authorization may be subject to re-disclosure by anyone who has access to the reminder or information and may no longer be protected by the federal privacy rules.

You may restrict the individuals or organizations to which your health care information is released, or revoke your authorization at any time; however, the revocation must be in writing and will become effective once we receive the revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

I authorize the use or discloser of my health information as described above. This notice is effective as of the date below and expires seven years from the date I last received services in this office.

Patient name printed ______________________ Date ______________________

Patient Signature ______________________ Authorized provider representative ______________________

Personal representative Printed ______________________ Personal representative signature ______________________

____
Description of personal representative's authority to act for the patient.

PATIENT CASE HISTORY

Name: ______________________ Date ______________

Address: ______________________________________

City: ______________ State: __________ Zip: ______________

Home Phone: ___-___-___ Work Phone: ___-___-___ Cell Phone: ___-___-___

Email Address: ______________ Occupation: ______________________

Date of Birth: ______________ Insurance ______________________ Gender: Male - Female

List any **Allergies**:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs☐ Latex ☐ Molds ☐ Penicillin ☐ Ragweed/Pollen ☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye ☐ Other: ______________

List any **Surgeries**:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist ☐ Other: __________

List **ALL** **Past Medical History** conditions:

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain ☐ Depression ☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting ☐ Fatigue ☐ Foot Pain ☐ Genetic Spinal Condition ☐ Hand Pain ☐ Headaches ☐ Hearing Problems ☐ Hepatitis ☐ High Blood Pressure ☐ Hip Pain ☐ HIV ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain ☐ Menstrual Problems ☐ Mid-Back Pain ☐ Minor Heart Problem ☐ Multiple Sclerosis ☐ Neck Pain ☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's ☐ Polio ☐ Prostate Problems ☐ Shoulder Pain ☐ Significant Weight Change ☐ Spinal Cord Injury ☐ Sprain/Strain ☐ Stroke/Heart Attack ☐ Other: ______________________

List Type of **Medications** you are taking:

☐ Anxiety ☐ Muscle Relaxors ☐ Pain Killers ☐ Insulin ☐ Birth control ☐ Cardiovascular ☐ Allergy ☐ Seizure ☐ Other: ______________

List your **Family History**:

☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Genetic Spinal Condition ☐ High Blood Pressure ☐ Heart Problems ☐ Multiple Sclerosis ☐ Neurological Problems ☐ Parkinson's ☐ Polio ☐ Prostate Problems ☐ Stroke/Heart Attack ☐ Please list all family members who had/has any of the problems above:

Example: Grandmother – High blood pressure

____

____

____

Have you had any auto or other accidents? ☐ No ☐ Yes

Describe: ____________________

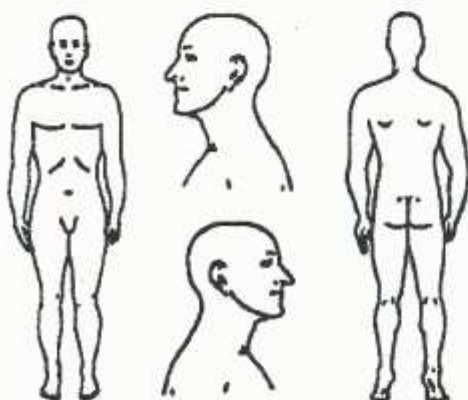
Date of last physical examination: ____________ Do you smoke? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes - how many per day? ____________

Do you drink caffeine? ☐ No ☐ Yes - how many per day? ____________

Do you exercise? ☐ No ☐ Yes (what forms and how often): ____________________

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce symptoms
- ☐ Resume normal activity level

What is your major complaint? ____________________ Date problem began? ____________

How did this problem begin (falling, lifting, etc.)? ____________________

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES - NO

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)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: ____________________

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc)? ____________________

What makes your pain better (ice, heat, massage, etc)? ____________________

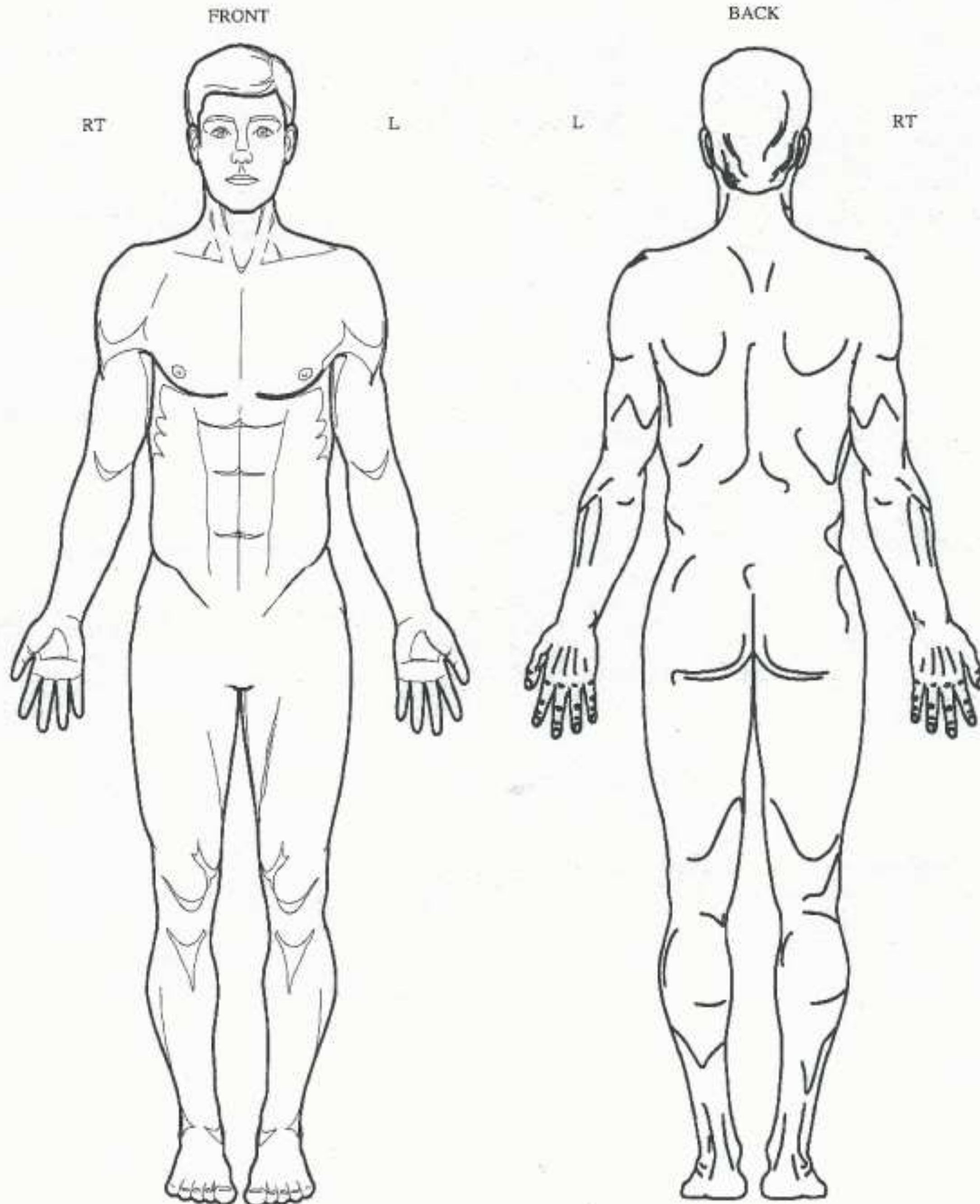
PAIN DIAGRAM

PATIENT NAME:______________________________ TODAY'S DATE:__________

PLEASE COMPLETE THE FOLLOWING "*PAIN DIAGRAM*" BY USING LETTERS AT THE LEFT TO INDICATE ON THE DIAGRAM YOUR AREAS OF PAIN:

PAIN (**P**)
TINGLING (**T**)
NUMBNESS (**N**)
BURNING (**B**)
STIFFNESS (**S**)

PATIENT'S SIGNATURE:______________________



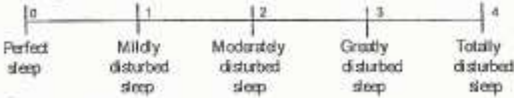
Functional Rating Index

For use with Neck and/or Back Problems only.

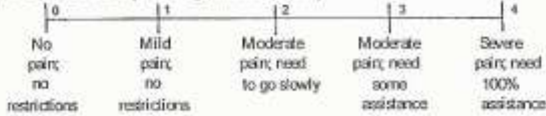
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.
For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

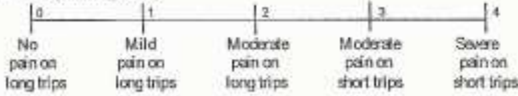
2. Sleeping



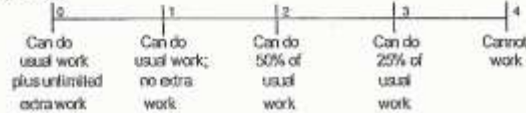
3. Personal Care (washing, dressing, etc.)



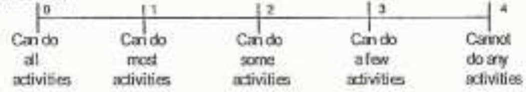
4. Travel (driving, etc.)



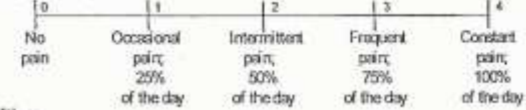
5. Work



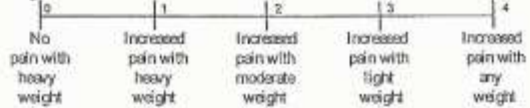
6. Recreation



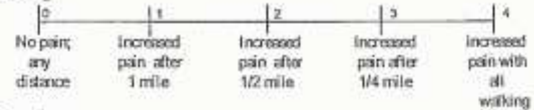
7. Frequency of pain



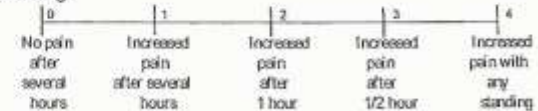
8. Lifting



9. Walking



10. Standing



Name ______________________ PRINTED ______________________ Plan ID ________ Total Score ________

______________________ Signature ______________________ Date

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INFORMED CONSENT

The primary treatment used by doctors of chiropractic is the spinal adjustment or manipulation.

- **The Nature of the Chiropractic Adjustment**
  I will use my hands or a mechanical device on your body in such a way as to move your joints. This may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel or sense movement along with this sound.

- **The Material Risks Inherent in Chiropractic Adjustment**
  As with any healthcare procedure, there are certain complications which may arise during a chiropractic adjustment. The most frequent complication involves stiffness or soreness following the first few days of treatment. Less frequently, complications can arise which include muscle strain, or strain /separation of the ribs. Even more rare are injuries to the disc, joint dislocation, fractures or injuries to the spinal nerves or arteries that can cause weakness or paralysis.

- **The Probability of Those Risks Occurring**
  Fractures or dislocations are rare occurrences and generally the result of some underlying weakness of the bone which we would check for during the taking of your history, examination, and/or x-rays. Injuries to the arteries are extremely rare, at most, a one in a million chance. Since even that risk should be avoided if possible, we also employ tests in our examination which are designed to identify if you may be susceptible to any neurological or vascular kind of injury.

- **Ancillary Treatment**
  In addition to chiropractic adjustment, I intend to use the following procedures during your treatments: muscular therapy, trigger point therapy, neuro-muscular re-education, ice packs, intersegmental mechanical traction, or massage. These procedures do not involve any additional significant risks.

The Availability and Nature of Other Treatment Options
Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care with prescription drugs such as anti-inflammatory muscle relaxants and/or pain killers,
- Surgery,
- No treatment at all.

- **Material Risks Inherent in Other Options and Probability of Such Risks Occurring**
Overuse of over-the-counter medication produce undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, pain tolerance, and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long-term use of over-the-counter medicines.

*Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's tolerance, self-discipline in not abusing the medication, and proper professional supervision. Such medications generally entail very significant risks, some with rather high probabilities.

*The risk in surgery includes adverse reaction to anesthesia, iatrongenic (doctor caused) mishap, risk of hospitalization (exposure to communicable disease, iatrogenic mishap, and expense), and an extended convalescent period. The probability of those risks occurring varies according to many factors.

- **The Risks and Dangers Attendant to Remaining Untreated**
Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read the above explanation of chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself 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.

Date: ______________________________

Signature: ______________________________

Printed Named: ______________________________

Signature of Parent/Guardian (if minor): ______________________________