



Keystone Chiropractic, LLC

4835 S Fulton Ave Ste 103, Tulsa, OK 74135

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Keystone Chiropractic we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, and HMO, PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or the health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have the right to confidential communications and to request restrictions relative to such contact. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to redisclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care

or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and /or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice we will notify you

in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint, or if you would like further information regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should contact:

Dr. Jared Bennett (918) 663-6045
Privacy/Security Officer

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of June 6, 2016. This notice, and any alterations of amendments made hereto will expire seven years after the date upon which the patient record was created.



Keystone Chiropractic, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge that I have received and read a copy of the Notice of the Privacy Practices of Keystone Chiropractic, LLC.

If you have any questions, please contact the privacy officer whose name and contact information is listed in the notice.

Name Printed

Signature

Date

If you are a minor, or if you are being represented by another party, please provide the appropriate person's:

Name Printed

Signature

Date

Relationship to the patient



Keystone Chiropractic, LLC

Today's Date _____/_____/20_____ File# _____

Name: _____ Female Male

What do you prefer to be called: _____

Birthday: _____/_____/_____ Age: _____ SS: _____-_____-_____

Home Address: _____
(Street Address) (City) (State) (Zip Code)

Home#: (____) _____-_____ Cell#: (____) _____-_____

Email: _____

Employer: _____

Employer Address: _____
(Street Address) (City) (State) (Zip Code)

Occupation: _____ Phone# (____) _____-_____

Marital Status: Single Married Divorced Widowed Separated

Spouse's Name: _____

Referred To This Office By: _____

Who Is Responsible For Your Bill, You and: Spouse Worker's Comp
 Auto Insurance Medicare

In Event of Emergency: Name: _____ Relation: _____

Home#: (____) _____-_____ Cell#: (____) _____-_____ Other#: (____) _____-_____

Who is your Med Doctor: _____ Phone#: (____) _____-_____

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- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
 - Our policy requires payment in full for all services rendered at the time of service, unless other arrangements have been made. If account is not paid within 30 days of the date of service and no financial arrangements have been made, you will be financially responsible for account, as well as legal fees, collection fees, and any other expenses incurred in collecting your account.
 - I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims, and assign all insurance benefits directly to the provider.
 - 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 in my medical status.

Signature _____ Date _____/_____/20_____



Keystone Chiropractic, LLC

TERMS OF ACCEPTANCE

This document constitutes informed consent for chiropractic services.

When a patient seeks Chiropractic health care, and we accept that patient for such care, it is essential for both to be working towards the same goal. This prevents confusion and disappointment.

A *vertebral subluxation* is a mechanical interference by the spinal bones to the transmission of energy and information over nerve pathways.

The only goal of this office is to keep the body as free from subluxation as possible. This is due to our absolute conviction that every human being functions better on all levels when fewer subluxations are present.

We do not offer to examine, diagnose, treat or give advice about any disease or condition, whether physical, mental, or emotional other than subluxation. However, if during the course of chiropractic examination we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a healthcare provider who specializes in that area.

It is the responsibility of each individual to keep us informed and updated regarding any accidents, injuries, surgeries, illnesses, medication, or other factors that could relate to the safety of receiving our services. **As with any practice, there are risks that may or may not correlate with chiropractic care. I acknowledge I have researched and am aware of such risks.**

I have read and understand the above statements. All question pertaining to my receiving Chiropractic services in this office have been answered to my complete satisfaction.

Name Printed

Signature

Date

Complete if patient is a minor child

I, being the parent or legal guardian of the above minor, have read and fully understand the above terms of acceptance. I hereby grant permission for him/her to receive straight chiropractic services at this office.

Name Printed

Signature

Date

Relationship to the patient



Keystone Chiropractic, LLC

PATIENT AUTHORIZATION REGARDING CHIROPRACTIC CARE BEING AN “OPEN-DOOR” ADJUSTING ENVIRONMENT

It is the desire of this office to provide chiropractic care in an “open-door” adjusting environment. An “open-door” approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. As a result, patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an “incidental disclosures” of health information. It is our view that the kinds of matters related in an “open door” environment are incidental matters. In the event you or someone else would not agree with us, we are providing this disclosure and requesting your authorization. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. If you choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Dr. Jared Bennett or on your relationship with our staff. Your signature indicates your authorization of this activity.

Name Printed

Signature

Date

If you are a minor, or if you are being represented by another party, please provide the appropriate person's:

Name Printed

Signature

Date

Relationship to the patient

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

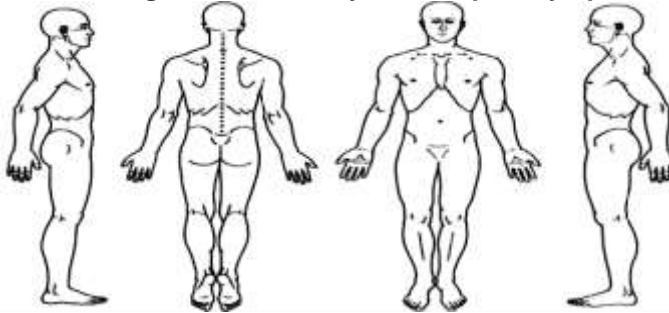
PATIENT INTAKE FORM

Patient Name: _____

Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Numb |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Tingly |
| <input type="checkbox"/> Diffuse | <input type="checkbox"/> Sharp with motion |
| <input type="checkbox"/> Achy | <input type="checkbox"/> Shooting with motion |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing with motion |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff | <input type="checkbox"/> Other: _____ |

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- | | | |
|--|---|---|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER physician | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> No one |

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ Weight _____ Age _____

Occupation _____

16. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

17. What type of exercise do you do?

- Strenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:

- | | | |
|---|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> ALS |

MEDICAL HISTORY

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Table with 6 columns: Past, Present, Past, Present, Past, Present. Lists various medical conditions such as Headaches, Neck Pain, High Blood Pressure, Heart Attack, Diabetes, Excessive Thirst, etc.

20. List all prescription medications you are currently taking:

21. List all of the over-the-counter medications you are currently taking:

22. List all surgical procedures you have had:

23. What activities do you do at work?

Form for question 23 with columns for Sit, Stand, Computer work, On the phone and frequency options: Most of the day, Half the day, A little of the day.

24. What activities do you do outside of work?

25. Have you ever been hospitalized? No Yes

if yes, why

26. Have you had significant past trauma? No Yes

Explain:

27. Anything else pertinent to your visit today?

Patient Signature: Date: