CAPITAL CHIROPRACTIC CENTER

Dr. Cal Melton

Name:_____

Address: Street:_____City:_____

State:_____ Zipcode:_____ _____Birth Date:_____

Phone:Home:_____Work:_____Mobile:_____

Email:_____

Occupation:_____Employer:_____

Emergency contact:_____Relationship:_____

Emergency contact's phone number:_____

Has a doctor or health professional ever told you that you have or had one of the following conditions? Please check all that apply.

- ☐ Congenital heart defect
- ☐ Gastrointestinal issues
- ☐ Psychological
- ☐ High cholesterol
- ☐ Poor balance or Recent falls
- ☐ Severe headaches
- ☐ Epilepsy/Seizure disorders
- ☐ Liver disease
- ☐ Lung disease
- ☐ Chemical dependency
- ☐ Lyme disease
- ☐ Multiple Sclerosis
- ☐ Joint tendon or Muscular pain
- ☐ Pacemaker
- ☐ Low blood pressure
- ☐ Abdominal pain/Bloating/Gas
- ☐ Coughing/Wheezing on excretion
- ☐ Rheumatoid Arthritis
- ☐ Ulcers
- ☐ Kidney disease
- ☐ Thyroid problem
- ☐ Stroke
- ☐ Hepatitis A, B, C
- ☐ Joint replacement/repair
- ☐ Skin problem
- ☐ High/Low blood sugar
- ☐ Emphysema
- ☐ Dizziness/Vertigo/Fainting/ Blackouts
- ☐ Prostate problem
- ☐ Circulation problem or Blood clots
- ☐ Sexually Transmitted Disease or HIV/AIDS
- ☐ Allergies
- ☐ Diabetes
- ☐ Painful bowels/Loose stool/Constipation
- ☐ Heart problem/Heart disease
- ☐ Osteoporosis
- ☐ High blood pressure
- ☐ Chest Pain/Angina/Palpitations
- ☐ Shortness of breath
- ☐ Gout
- ☐ Anemia
- ☐ Depression
- ☐ Tuberculosis
- ☐ Asthma/Bronchitis/Pneumonia/Chronic cough
- ☐ Latex allergy
- ☐ Other:_____

Provide details regarding condition checked above:_____

_____

Are you under a doctor's care: ☐ YES ☐ NO. If yes, please explain and give doctor's name:_____

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Have you **recently** noted:

Weight loss/gain	Nausea/Vomiting	Weakness	Numbness/Tingling
Fatigue	Dizziness	Shortness of breath	Headaches
Fever/Chills/Sweats	Pain at night	Difficulty swallowing	Change of appetite

Are you pregnant? ☐ Yes ☐ No How much water do you drink in a day?_____

How many cigarettes do you smoke a day? _____

How much coffee or caffeinated beverages do you drink a day? (ounces)_____

How many alcoholic beverages do you consume in one week?_____

What forms of exercise do you practice and how often?_____

Accidents, injuries, or major illnesses including motor vehicle (include date):

_____

Surgeries (include date):_____

_____

Medications, vitamins, herbs, teas, over-the-counter medications and supplements (include dosage):_____

_____

Family medical history: (Please list major illnesses in your close family such as diabetes, heart disease, high blood pressure, neurological disorders, psychological disorder, orthopedic disorders, etc.)_____

_____

What other practitioners are you currently seeing for this condition? (Please list all with the frequency, duration, and treatment involved)_____

Describe what condition you are here to be treated for and how long you have had it (date of onset):-

_____

_____

Have you had any prior episodes for this condition? How many?_____

Have you undergone any diagnostic testing: ☐ Nerve Conditions Velocity ☐ EMG ☐ Bone Scan ☐ MRI

☐ Cardiac Stress Test ☐ CT Scan ☐ Blood Test ☐ Doppler Studies ☐ Urinalysis ☐ X-rays ☐ Other

Results from the above test:_____

_____

Was the onset due to: ☐ Injury at home ☐ Slow onset ☐ Chronic ☐ Work related ☐ Repetitive motion ☐ Sports ☐ Recreational ☐ Trauma ☐ Unknown ☐ Other:_____

Was the onset due to : ☐ Backward bending ☐ Forward bending ☐ Twisting R or L ☐ Crushing ☐ Heavy lifting ☐ Illness ☐ Trauma ☐ Overuse ☐ Other:_____

What was the onset speed of your injury ☐ Gradual ☐ Sudden

Which of the following describes your symptom trend: ☐ Improving ☐ Unchanging ☐ Worsening

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What is the frequency of your pain? ☐ Constant ☐ Intermittent/Daily ☐ Occasional (less than daily)

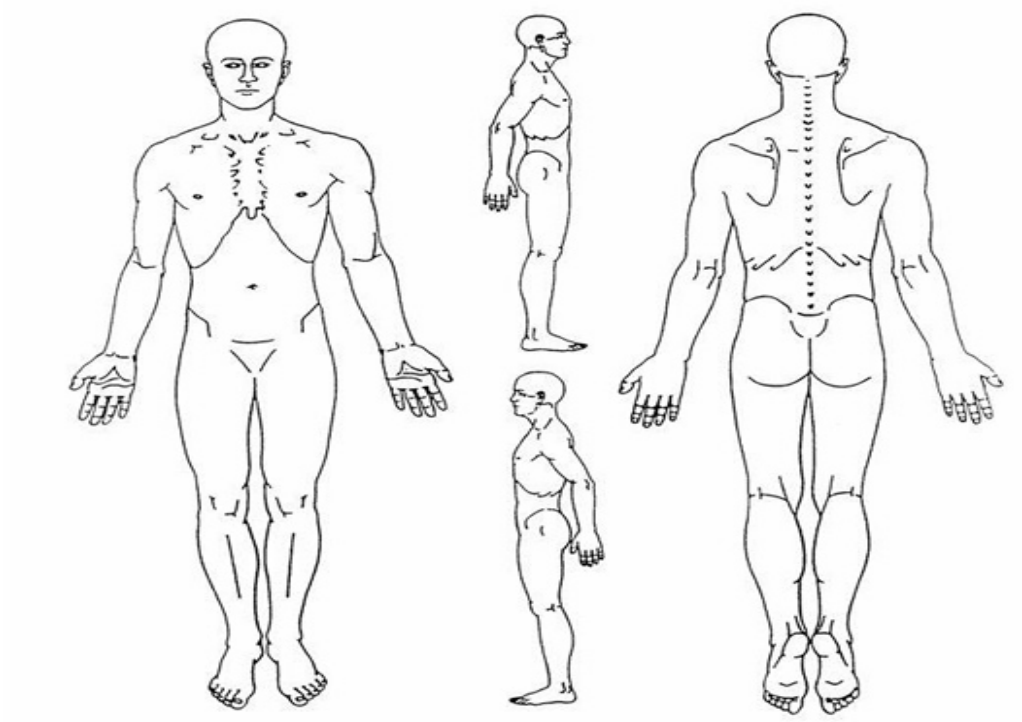
☐ Sporadic (less than weekly) ☐More specifically_____

What is your pain intensity on average? (0= no pain, 10= worst imaginable)

At its worst_____ At its best_____ At rest_____

At night _____With movement (please specify movements)_____

Please indicate where your pain or symptoms are by shading areas below



What specific remedies or movement decrease your pain?_____

Does it radiate and if so where?_____

Does your pain change morning to noon to evening? Describe:_____

_____

What is the quality of your pain? ☐ Sharp ☐ Dull ☐ Achy ☐ Stabbing ☐ Throbbing ☐ Pulsating ☐ Deep ☐ Boring ☐ Shooting ☐ Searing ☐ Radiating ☐ Tearing ☐ Gripping ☐ Other:_____

Do you have: ☐ Pin and needless ☐ Numbness ☐ Tingling ☐ Loss of sensation ☐ Hypersensitivity ☐ Strength loss If so where?_____

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I certify that the above information is correct to the best of my knowledge. I have disclosed all medical condition that I am aware of and will inform the practitioner of any changes in my health status. I understand that these service are a health aid and not a substitute for a doctor's care.

Signature:_____Date:_____

MY PRIVACY

I have received a copy of the **Notice of Privacy Practices**. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to; conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing treatment; Obtain payment from third-party payer; Conduct normal healthcare operations such as quality assessments and accreditation.

_____ _____

Signature of patient or person acting on patient's behalf Date

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and electrical stimulation to include ARP program therapy, on me (or on the patient named below, for whom I am legally responsible) by Dr. Cal Melton, D.C. and/or other licensed doctors of chiropractic and/or registered chiropractic assistants who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date _____

Witness Signature _____ Date_____

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INSURANCE INFORMATION

Patient Last name:	First Name:	Middle

Insurance: We need a copy of your card(s) for our records.

Insurance Company_____

Insured's Name_____DOB _____

Social Security# _____

ID/Policy # _____

Insurance phone #_____

Responsibility Party: Complete this section if you are not the patient but are responsible for the payments.

Name:_____

Relationship to Pateint:_____

Home Address_____Apt#_____

City_____State_____Zip_____

Home Phone#_____Work Phone#_____ Mobile Phone#_____

MY FINANCIAL RESPONSIBILITY

I certify that the above information is correct. I understand that I am **personally responsible** for all the services not paid for by my insurance. I am also responsible for any annual deductibles applicable, co-payments, or non-covered services that may be required by my insurance plan. If I am a PIP patient, depending on my auto coverage plan, I may be responsible for 20% of each visit. I further understand that the office charges a $25 fee for returned checks.

The **office reserves** the right to charge for appointments canceled without 24 hours notice. One "*no-show*" is allowed for every patient per six months of care. After that the office will charge up to *100%* of the *cash value* of the scheduled appointment, *not just a co pay*. A patient that is *late* for an appointment will have the option to use the remainder of the scheduled appointment at full price.

I authorize the **release** of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

X_____ _____

Patient/Legal guardian Signature Date

Dr. Walter C. Melton, D.C.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

(45 CFR 164.520)

PLEASE REVIEW THIS NOTICE CAREFULLY.

This notice describes how medical information about you may be used and disclosed and you can get access to that information as required by 45 CFR 164.520.

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. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated. This Notice may be amended or revised at which time you will be provided the revised or amended Notice to review.

NO CONSENT REQUIRED

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

- (a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.

- (b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about

health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice 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.

- (c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

1. The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) Any information is deleted that would identify you.

(b) To a company or person who is not employed by the practice to provide a service such as billing insurance and/or electronic records. These persons/companies are called "Business Associates." Only that information necessary to perform the service will be submitted to the business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI.

(c) To a person that you designate as a personal representative who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

- (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make

such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(p) Disclosure of immunizations to schools required for admission upon your informal agreement.

APPOINTMENT REMINDER

The Practice 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. Appointment reminders are used by the Practice. The Practice will use those methods which you designate at the end of this Notice, such as: a) a postcard mailed to you at the address provided by you; b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone; or sending you an email or text message.

DIRECTORY/SIGN-IN LOG

The Practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

- (b) If you are not present, the Practice 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.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

1. You have the right to:

(a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

Restrictions from your health plan (insurance company): You have the right to request that we restrict disclosure of your medical information to your health plan for covered services, provided the disclosure is not required by other laws. Services must be paid in full by you, out of pocket.

(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request

(e) Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

(g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

(h) Receive notice of any breach of confidentiality of your PHI by the Practice.

(i) Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

(j) Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov or to the Florida Attorney General, Office of the Attorney General, PL-01 The Capitol, Tallahassee, FL 32399-1050, 850 414-3300 if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

(k) Request copies of your PHI in electronic format.

To obtain more information on, or have your questions about your rights answered; you may contact the Practice's Privacy Officer, Callie Griffin, at 850-878-2363or via email at dcsdc14@gmail.com.

PRACTICE'S REQUIREMENTS

1. The Practice:

- (a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

- (b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the following State statutes:

  Section 381.004 relating to HIV testing, Chapter 384 relating to sexually transmitted diseases, Section 456.057 relating to patient records ownership, control and disclosure and Section 501.171 relating to protecting your personal information, Social Security and driver license numbers, credit or debit card information, financial accounts information, email address, and medical information.

- (c) Is required to abide by the terms of this Privacy Notice.

- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

- (e) Will distribute any revised Privacy Notice to you prior to implementation.

- (f) Will not retaliate against you for filing a complaint.

QUESTIONS AND COMPLAINTS

You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below whom is the Privacy Officer and Contact person appointed for this practice. The Privacy Officer is Callie Griffin.

You may file a complaint with the Privacy Officer if you believe that your privacy rights have been violated relating to release of your protected health information. You may, also, submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the Privacy Officer. We will not retaliate against you in any way if you file a complaint.

EFFECTIVE DATE

This Notice is in effect as of 08/10/2021.