

Abundant Life Wellness Center

Dr Joe Accurso III

CONFIDENTIAL PATIENT INFORMATION

(Please Print clearly)



Personal Information

Full Name _____ Date _____

Mailing address _____

Street _____ City _____ State _____ Zip _____

Home Phone () _____ Work # () _____ Cell # () _____

Best time and place to contact you _____ SS# _____

Spouse/Guardian Name _____ Email: _____

Marital Status: M S W D Age _____ Birth date _____ No. of children _____

Height? _____ Weight ? _____ Pregnant? _____ Occupation _____

Employer's Name and Address _____

Spouse Occupation/Employer _____

WHO MAY WE THANK FOR REFERRING YOU? _____

ADDRESSING WHAT BROUGHT YOU INTO THIS OFFICE:

If you have no symptoms or complaints and are here for Wellness Services, please skip to the "General History" section

I. HEALTH CONCERNS

List health concerns problem % of time according to their severity	Rate of severity 1= mild 10= worst	this episode start?	When did the condition before, when?	If you had begin with an injury?	Did pain is present
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

What have you done for this condition? Was it of benefit?

I do (do not) have a family history of this or similar symptoms (Please explain)

What activities aggravate your condition? _____

Other Doctor's seen for this condition: "Limited Scope" Chiropractor, "Wellness" Chiropractor, Medical Dr. _____ Dentist _____
 Other _____

1. Name/Address: _____
 When: _____ What did they say was wrong? _____
 What did they do? _____ Did it help? _____
2. Name/Address: _____
 When: _____ What did they say was wrong? _____
 What did they do? _____ Did it help? _____

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

Is this condition interfering with your: work____ sleep____ daily routine____ sports/exercise____

Other _____

Are you unable to do certain activities that you enjoy because of this pain, illness, condition? (i.e. sports, walk, pick up grandchildren, etc.) If so, what?

What lesson(s) have you taken home from your healing process to date?

II. GENERAL HEALTH HISTORY SECTION

Have you had any surgery? (Please include all surgery)

1. Type _____ When _____ Doctor _____
2. Type _____ When _____ Doctor _____
3. Type _____ When _____ Doctor _____
4. Type _____ When _____ Doctor _____

Accidents and/or injuries: auto, work related, or other (Especially those related to your present problems).

1. Type _____ When _____ Hospitalized ____ Yes ____ No
2. Type _____ When _____ Hospitalized ____ Yes ____ No
3. Type _____ When _____ Hospitalized ____ Yes ____ No

Have you ever had x-rays taken? _____ When? _____ Where? _____

Area of body: _____

Do you wear orthotics or heel lifts? Yes _____ No _____

CURRENT MEDICINE(S)/SUPPLEMENTS:

Please list any medications/drugs you have taken in the past 6 months **and why**: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and

why: _____

The type of diet I usually follow is classified as: _____

III. PAST HEALTH HISTORY:

Mark the following conditions you may have had or have now (- have had +have now)

Allergy	Depression	Gout	Menstrual Cramps	Pneumonia
Anemia	Diabetes	Headaches	Migraines	Ringing in Ears
Anxiety	Diarrhea	Heart Attack	Miscarriage	Scoliosis
Arteriosclerosis	Digestive Prob.	Heart Disease	Mood Changes	Sinus Problems
Arthritis	Dizziness	High Blood Pres.	Multiple Sclerosis	Sprains / Strains
Asthma	Eczema	HIV (Aids)	Mumps	Stroke
Back Pain	Emphysema	Irreg. Periods	Neck Pain	Thyroid Prob.
Cancer	Epilepsy	Learning Disorder	Nervousness	Trouble concentrating
Cold Sores	Fractured Bones	Low Blood Sugar	Neuritis	Trouble Sleeping
Constipation	Freq. Infections	Low Energy	Pleurisy	Tuberculosis
Convulsions	Gall Bladder Prob.	Measles		Ulcers

Other (please explain) _____

Please list your top three stresses in each category:

1. Physical stress (falls, accidents, work postures, etc.)
 - a. _____
 - b. _____
 - c. _____
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
 - a. _____
 - b. _____
 - c. _____
3. Psychological stress (work, relationships, finances, self-esteem, etc.)
 - a. _____
 - b. _____
 - c. _____

How do you grade your physical health? Excellent___ Good___ Fair___ Poor___ Getting better___ Getting worse ___

How do you grade your emotional/mental health? Excellent___ Good___ Fair___ Poor___ Getting better___ Getting worse ___

Is there anything else which may help to better understand you, which has not been discussed?

Why are you here at this point in time?

FEMALES: Is there a possibility of your being pregnant? Yes No

The information I've provided is accurate and I consent to a professional examination. Payment is due at time service is provided.

Signature _____ Print Patient Name _____ Date _____

**TERMS OF ACCEPTANCE
CHIROPRACTIC INFORMED CONSENT**

When a patient seeks chiropractic health care and we agree to provide this care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method with which it will be obtained. This prevents any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses. This misalignment results in a lessening of the body's God-given, innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation; however, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's God-given, innate wisdom. Our only method is specific adjusting to correct vertebral subluxation. However we may use other procedures to help your body hold the adjustments.

I, _____, have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

Signature _____ Date

Consent to evaluate and adjust a minor child

I, _____, being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature of parent/legal guardian _____ Date

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant. The above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

Signature _____ Date

NOTICE OF PRIVACY PRACTICES AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Abundant Life Wellness Center & Dr Joe Accurso III

EFFECTIVE DATE OF THIS NOTICE: 1-1-2006

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI.
- Your privacy rights in your PHI.
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Betsy Heald, our Privacy Officer, at 9040 S.W. 152 Street, Palmetto Bay 33157.

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. The information in your medical records will be used to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medical records so that other health care professional can make informed decisions about your care. For example, we may ask you to have laboratory tests, and we may use the results to help us reach a diagnosis. Many of the people who work for our practice – including, but not limited to, our doctors and staff – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointments and Reminders. Our practice may use and disclose your PHI to contact you, by mail, email, or phone, to remind you of an appointment or as a follow up on treatment.

5. Non-Medical Communications. Our practice may use your PHI to contact you for non-medical reasons. For example, we may send you a birthday card or a holiday greeting via mail, or email.

6. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives. We may treat you in an open treatment area and some incidental PHI may be overheard by other patients being treated at the same time. You can request a private consultation with the doctor by phone or at adjusting hours.

7. Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you. For example, we may send you newsletters, or emails that may include information about our practice, health related issues and products and services.

8. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- A. maintaining vital records, such as births and deaths;
- B. reporting child abuse or neglect;
- C. preventing or controlling disease, injury or disability;
- D. notifying a person regarding potential exposure to a communicable disease;
- E. notifying a person regarding a potential risk for spreading or contracting a disease or condition;
- F. reporting reactions to drugs or problems with products or devices;
- G. notifying individuals if a product or device they may be using has been recalled;
- H. notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information; and
- I. notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- A. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement;
- B. Concerning a death we believe has resulted from criminal conduct;
- C. Regarding criminal conduct at our offices;
- D. In response to a warrant, summons, court order, subpoena or similar legal process;
- E. To identify/locate a suspect, material witness, fugitive or missing person; and
- F. In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Betsey Heald**, our Privacy Officer, at **9040 S.W. 152 Street, Palmetto Bay, FL. 33157** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Betsey Heald**, our Privacy Officer, at **9040 S.W. 152 Street, Palmetto Bay, FL. 33157**. Your request must describe in a clear and concise fashion:

- A. the information you wish restricted;
- B. whether you are requesting to limit our practice's use, disclosure or both; and
- C. to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Betsey Heald**, our Privacy Officer, at **9040 S.W. 152 Street, Palmetto Bay, FL. 33157** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Betsey Heald**, our Privacy Officer, at **9040 S.W. 152 Street, Palmetto Bay, FL. 33157**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Betsey Heald**, our Privacy Officer, at **9040 S.W. 152 Street, Palmetto Bay, FL. 33157**.

All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Betsey Heald**, our Privacy Officer, at **9040 S.W. 152 Street, Palmetto Bay, Fl. 33157**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Betsey Heald**, our Privacy Officer, at **9040 S.W. 152 Street, Palmetto Bay, Fl. 33157**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Betsey Heald at 9040 S.W. 152 Street, Palmetto Bay, Fl. 33157.**