

Schneider Clinic P.C.

Patient Information

First		M.I.	
Last			
Nickname			
Street			
City			
State		Zip	
Social Security #			
Date of Birth			
Spouse's Name			
Spouse's Social Security #			
Spouse's Date of Birth			
Home Phone #			
Work Phone #			
Cell Phone #	Verizon AT&T Sprint TMobile Other		
	Please circle primary phone #		
E - Mail Address (For Patient-Doctor communication) <i>Remains Confidential</i>			

Employer Information

Occupation	
Company	
How long at Employer?	
Address	
Emergency Contact	Name: Address: Phone #:
Is your Condition due to:	Auto Accident Personal Injury Work Injury Other:
Do you have health Insurance?	Relationship to Insured? Self, Spouse, Child, Other:
Employer of Insured Person - if not self:	
I will be paying today by:	Cash Check Credit Card
Referred By:	

AUTHORIZATIONS:

- A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
- B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
- C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

PATIENT HISTORY

NAME: _____ DATE: _____ DOB: _____ Pt #: _____

List any **Allergies**:

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

List any previous **Surgeries** (please include dates):

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 _____ Pain Killers _____
 Muscle Relaxers _____ Insulin _____
 Birth Control _____ Seizure _____
 Allergy _____ Cardiovascular (heart-related) _____
 Other _____

List your **Family History** (write appropriate letter in space provided): **F** (Father), **M** (Mother), **S** (Sibling), **C** (Child)

- Arthritis _____ Asthma _____ Back Pain _____ Cancer _____ Diabetes _____
 Epilepsy _____ Genetic Spinal Condition _____ High Blood Pressure _____ Heart Problems _____
 Multiple Sclerosis _____ Neurological Problems _____ Parkinson's _____ Polio _____
 Prostate Problems _____ Stroke/Heart Attack _____ Other: _____

Have you had any auto or other accidents? Yes No

If yes, describe: _____

Date of last physical examination: _____ Name of Family Physician: _____

Do you smoke? No Yes- how many packs per day? _____

Do you drink alcohol? No Yes- how many glasses per day? _____

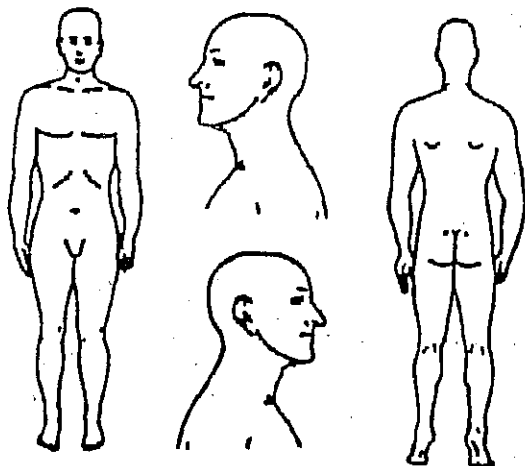
Do you drink caffeine? No Yes- how many glasses per day? _____

Do you exercise? No Yes- what forms and how often? _____

WOMEN ONLY: Are you currently pregnant? No Yes

Number of births? 1 2 3 4 5+

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



For Office Use Only:

Last x-ray _____

Last seen _____

Last cond tx _____

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? Constant (76-100% of day) Frequent (51-75 % of day)
 Occasional (26-50% of day) Intermittent (0-25% of day)

Describe the nature of your symptoms: Sharp Dull Burning Shooting Radiating Pain
 Tightness Stabbing Throbbing Numbness Tingling 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 (bending, sitting, reaching, etc)? _____

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

Have you been elsewhere for treatment? Were any diagnostic studies done (x-rays or MRI)? _____

Patient Signature _____ Date _____

**Schneider Clinic P.C.
Privacy Practices**

PATIENT ACKNOWLEDGMENT FORM

Patient Acknowledgment of Understanding of Schneider Clinic P.C.'s Privacy Practices

Patient's name: _____ Date of birth: _____

SSN: _____ Previous name: _____

I understand that the patient's health information is private and confidential. I understand that Schneider Clinic P.C. works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Schneider Clinic P.C. may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. [*In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.]

Schneider Clinic P.C. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is available upon request. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Schneider Clinic P.C. may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Schneider Clinic P.C. will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Schneider Clinic P.C. has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Schneider Clinic P.C. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Schneider Clinic P.C.'s "Notice of Privacy Practices".

Name (Signature)

Date

Time

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

Schneider Clinic P.C.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 28, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1.00 for each page, \$20.00 per hour (with a minimum of \$20.00) for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. Contact Officer: DR. MARK SCHNEIDER. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Mark Schneider

Telephone: 574-293-7000