WELCOME TO TYO CHIROPRACTIC

1818 W Gore Blvd Lawton, Ok. 73501 P: 580-699-5115 F: 580-699-5120

DATE: ___________________

NAME: ____________________________________ SSN: ___________________ BIRTHDATE:_____________

ADDRESS/CITY/STATE/ZIP:____

HOME PHONE: _________________ WORK PHONE: _______________ CELL PHONE: __________________

AGE: __________ SEX: M OR F Marital Status: ( )married ( ) divorced ( ) single

EMAIL: ____

Ethnicity: ____________________________________ Primary language: ____________________________

EMPLOYER: ________________________________ OCCUPATION: ________________________________

Emergency Contact/Access to Records: ______________________________PHONE:___________________

Insurance information:

Insured's Name: __________________________________ DOB: __________________________________

Guarantor Name: __________________________________DOB: __________________________________

Insurance Company ________________________________Ins Phone: _______________________________

Group/Account#:__________________________________Policy#:__________________________________

Allergies : ( ) None ( )Adhesive ( )Codeine ( )Iodine ( )Latex ( )Penicillin ( ) Aspirin ( )Sulfa

( ) other: ____

MEDICAL HISTORY: (PLEASE CHECK ALL THAT APPLY TO YOU):

( )Anxiety ( )Cancer ( )GI Stomach Ulcer ( )High Cholesterol ( )Stroke
( )Arthritis ( )Depression ( )Heart Condition ( )Hypertension ( )HIV
( )Asthma ( )Diabetes ( )Tuberculosis ( )GERD ( )Seizures
( )COPD ( )Kidney Dis. ( )Thyroid Disorder ( )Hepatitis ( )None
( )Other: ____

SURGICAL HISTORY: ( )YES ( )NO If yes, list with

____

MEDICATIONS: ( )YES ( )NO If yes, please list:

____

FAMILY HISTORY:

____

SOCIAL HISTORY:

Smoking History: ( ) Never Smoked ( )Cigarettes PPK: _____ ( )Cigars: Per Day_____

Alcohol History: ( ) No history of use ( )Occasional ( )Social ( )Heavy

Rate your pain on a scale from 1 (best) to 10 (worst) currently

1 2 3 4 5 6 7 8 9 10

Rate your pain on a scale from 1 (best) to 10 (worst) at its best

1 2 3 4 5 6 7 8 9 10

Rate your pain on a scale from 1 (best) to 10 (worst) at its worst

1 2 3 4 5 6 7 8 9 10

Please check your symptom area(s) and circle the affected area(s):

_____ Neck

_____ Mid Back

_____ Low Back

_____ Chest

_____ Pelvis

_____ Arm

_____ Hand

_____Hip

_____Leg

_____Foot

_____Shoulder

_____Elbow

_____Knee

_____Other: __________________

HIPAA Notice of Privacy Practices
Tyo Chiropractic

1818 W Gore Blvd. Lawton, Ok. 73501
P: 580.699.5115   F: 580.699.5120

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes you rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of PHI: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose you PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will b e asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose you PHI in following situations without your authorization. These situations include: as Required By Law, PHI issues as required by law, Communicable Diseases: Health Oversight Abuse or Neglect: FDA requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of HHS to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: The following is a statement of your rights with respect to your PHI. You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically. You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you be mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of HHS if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI, If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Printed Name: ____

Signature: ____ Date: ______________________

Informed Consent

I hereby consent to the performance of chiropractic adjustments and other chiropractic procedures, on myself (or on the patient named below, for whom I am legally responsible) by **Todd T. Tyo, D.C**., and/or other licensed doctors of chiropractic who now or in the future provide chiropractic adjustments and other types of treatment for me. This consent includes other doctors of chiropractic that are employed, associated with, or serve as back-up for **Todd T. Tyo, D.C.,** whether or not their names are listed on this form.

I understand and consent to the following procedures:

- ✓ Examination
- ✓ X-rays
- ✓ Adjustments
- ✓ Mobilization
- ✓ Ultrasound
- ✓ Muscle Stimulation
- ✓ Traction

I have an opportunity to discuss with Todd T. Tyo, D.C. and/or associate doctor the various types of treatment, including neck and spinal/extremity adjustments, that have been proposed to me for my condition, and the purpose and objectives of these chiropractic procedures. I understand that the results from the chiropractic treatment are not guaranteed for my condition.

I have been informed about the risks and benefits of chiropractic adjustments and other chiropractic procedures, and understand that, there are some uncommon potential serious risks to chiropractic adjustments and procedures, including, but not limited to, sprains, fractures, disc injuries, dislocations, nerve injuries, and strokes specifically from neck adjustments. I understand and have had the opportunity to ask about risks and benefits the proposed treatment and of other alternative types of treatment for my condition.

I have had the opportunity to read this form, understand the above statements, accept the risks mentioned, and hereby consent and agree to chiropractic treatment over the entire course of treatment for my present condition and any future conditions for which I seek care for.

PATIENT NAME (PRINT): ________________________________ DATE: ___________________

X____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

NAME: ______________________________ RELATIONSHIP: ___________________________
Indicate your name and relationship (parent/guardian/personal representative) if signing for patient (minor).

DOCTOR: ____ DATE: ___________________

OFFICE/WITNESS SIGNATURE: ____________________________ DATE: ___________________