Dr. Tripp Puhl DC, CCSP

CONFIDENTIAL PATIENT INFORMATION

Date _______________

Name ___________________________________Sex ____ D.O.B. __________ Age: _____ SS# _________________________ Marital Status _________

Address ____ City ______________________ State _________________ Zip Code ________________

Home Phone: _____________________ E-mail Address:______________________________________

Occupation: _____________________ Company Name_______________________ Address____

Work Phone:_________________ Cell Phone:_______________________________

____

Guardian/Spouse Full Name | Guardian/Spouse's DOB | Guardian/Spouse's Employer | Address | Phone Number

Name of nearest relative (not your spouse): ______________________________________ Phone ____

Who referred you to our office? ____

Who Is Your Primary Care Doctor? ____

Is your visit due to an auto or work related accident? No Yes

(IF YES, STOP! Please see receptionist for an accident injury report.)

List other doctor(s) seen for this condition __ ____

Personal/Family Medical History
(if any of the following are relevant to your medical history, please check the appropriate box, **S=Self, M=Mother, F=Father**)

S M F		S M F		S M F		S M F	
☐☐☐	Cancer	☐☐☐	Muscular Dystrophy	☐☐☐	Rheumatic Fever	☐☐☐	Digestive Disorders
☐☐☐	Polio	☐☐☐	Multiple Sclerosis	☐☐☐	Sinus Trouble	☐☐☐	Scarlet Fever
☐☐☐	Tuberculosis	☐☐☐	Convulsions	☐☐☐	Nervousness	☐☐☐	Low Back Pain
☐☐☐	High Blood Pressure	☐☐☐	Epilepsy	☐☐☐	Asthma	☐☐☐	Numbness
☐☐☐	Heart Trouble	☐☐☐	Concussion	☐☐☐	Dizziness	☐☐☐	Arthritis
☐☐☐	Diabetes	☐☐☐	Hepatitis	☐☐☐	German Measles	☐☐☐	Venereal Disease
☐☐☐	Chest Pain	☐☐☐	Headaches	☐☐☐	Neck Pain	☐☐☐	Poor Circulation

Describe any surgeries/operations you've had and the dates:

____

____

Accident History:

☐Job ☐Auto ☐Other 1.____ Date:___________________

☐Job ☐Auto ☐Other 2.____ Date:___________________

☐Job ☐Auto ☐Other 3.____ Date:___________________

Have you been treated by a physician for any other health condition in the last year? ☐ Yes ☐ No

Describe Condition ____ Date of last physical exam ________________________

Are you now taking any medication? ☐ Yes ☐ No. What kind? ____

Are you allergic to any medication? ☐ Yes ☐ No. What kind____

Are you pregnant? ☐ Yes ☐ No ☐ Does not apply. Date of last menstrual period: ____

Do you have insurance? ☐ Yes ☐ No Company

____

I.D. Number _____________________________ Policy Group Number ____

Please Describe Present Major Complaints
(Please rate each complaint 1-10, 10 being the worst pain you've ever had)

1.____ _______

2.____ _______

3.____ _______

4.____ _______

5.____ _______

List other doctor(s) seen for this/these condition(s)
____

____

Symptoms are worse in the: ☐Morning ☐Afternoon ☐Night

When and How occurred?____

____

Symptoms Developed From: ☐Job Related Duty ☐Auto Accident ☐Other Accident ☐Illness ☐Unknown Cause ☐Gradual Onset Date Occurred:_____________

Symptoms have persisted for: ___ Hour(s) ___ Day(s) ___ Week(s) ___ Month(s) ___ Year(s)

Symptoms/Complaints: ☐ Come and Go ☐ Are Constant

Have you ever had this before: ☐ No ☐ Yes When: ______________

What do you think is causing your symptoms? ____

____

Please check the following activities that AGGRAVATE your condition:

☐Bending ☐Reaching ☐Straining at Stool ☐Coughing ☐Sitting ☐Turning Head
☐Lifting ☐Sneezing ☐Walking ☐Lying Down ☐Standing ☐Other ______________________

Please check the following activities that RELIEVE your condition:

☐Ice ☐Heat ☐Acetominophen ☐Ibuprofen ☐Rest ☐Lying Down ☐Sitting ☐Other______________________________

Please Check Any Additional Symptoms You May Be Experiencing:

☐Blurred Vision ☐Ringing in ears ☐Cold feet ☐Cold hands ☐Cold Sweats ☐Concentration Loss ☐Constipation
☐Depression ☐Diarrhea ☐Fainting ☐Fatigue ☐Fever ☐Insomnia ☐Light bothers eyes
☐Loss of balance ☐Loss of smell ☐Loss of taste ☐Low resistance to colds ☐Muscle Twitching ☐Numbness in fingers
☐Buzzing in ears ☐Shortness of breathe ☐Stiff neck ☐Upset Stomach ☐Numbness in toes

Do you take any vitamin or mineral supplements? ☐Yes ☐No

If yes, what are you taking? ____

____

I hereby certify that the above information is correct to the best of my knowledge. I will not hold my treating physician or any staff member of Dr. Tripp Puhl DC, CCSP responsible for any errors or omissions that I may have made in the completion of this form.

Patient's (Parent or Guardian's) Signature: **Date:**
____

Dr. Tripp Puhl DC, CCSP

INFORMED CONSENT

**Please read and review carefully.*

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this clinic. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE

Soreness – Chiropractic manipulations/adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your treating physician in you experience soreness or discomfort.

Soft Tissue Injury – Occasionally chiropractic treatment my aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury – Manual manipulations/adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-manipulation/adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns – Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but if it occurs you should report it to your treating physician, or a staff member of Dr. Tripp Puhl DC, CCSP.

Stroke – Stroke is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37 No. 2, June, 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical (neck) manipulations.

Other Problems – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your treating physician promptly.

- This clinic currently does not provide x-ray services. Should x-rays be necessary, Dr. Puhl will discuss the process for obtaining films. These films will be on file where they may be seen at any time. The treating physician will not be held responsible for any pre-existing medically diagnosed conditions.

- I understand and agree that health and accident insurance 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. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. 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. It is my understanding that my credit may be checked if Dr. Tripp Puhl DC, CCSP extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the Dr. Tripp Puhl DC, CCSP and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment.

I hereby authorize **Dr. Tripp Puhl, DC CCSP** and staff, to provide and guide treatment deemed necessary to myself. He has explained that there is no guarantee of the effectiveness of the treatment. The risk involved in Chiropractic Manipulations/Adjustments is minimal, but are still a possibility.

If you have any questions concerning this form or the above statements, please ask your treating physician.

Having carefully read the above information, I hereby give my informed consent to have chiropractic treatment administered from my treating physician and staff of Dr. Tripp Puhl DC, CCSP.

Patient's (Parent or Guardian's) Signature: **Date:**

Treating Physician's Signature: Date:

Dr. Tripp Puhl DC, CCSP

ASSIGNMENT OF BENEFITS (AOB)

PATIENT'S NAME: **DATE:**

ASSIGNMENT OF BENEFITS:

I hereby assign all medical/chiropractic benefits, to include major medical, personal injury protection (PIP) and medical payments (Med Pay) to which I am entitled**. I hereby authorize and direct my insurance carrier(s) and/or attorney's, including major medical, PIP and Med Pay and any other health / medical plan, to issue payment check(s) directly to Dr. Tripp Puhl, DC, CCSP for Medical/Chiropractic services rendered to myself and/or my dependants regardless of my insurance benefits, if any.**

- **I understand that I am responsible for any amount not covered by insurance.**

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize **Dr. Tripp Puhl, DC, CCSP** to: 1) release any information necessary to insurance carriers regarding my illness and treatments; 2) to process insurance claims generated in the course of examination or treatment; and 3) to allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical/chiropractic services from **Dr. Tripp Puhl, DC, CCSP,** on behalf of myself and/or my dependants, and understand that by making this request, I become fully responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature **Date**

Witness **Date**

DOI: ________________

******* This form allows this office to directly bill and receive payment from all insurance carriers and/or attorney's.**

Dr. Tripp Puhl DC, CCSP

NOTICE OF PRIVACY PRACTICES

**Please read and review carefully.*

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

Dr. Tripp Puhl DC,, CCSP uses health information about you for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of **Dr. Tripp Puhl DC, CCSP**

How Dr. Tripp Puhl DC, CCSP
May Use or Disclose Your Health Information

For Treatment. **Dr. Tripp Puhl DC, CCSP** may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions. **Dr. Tripp Puhl DC, CCSP** may use your health information when referring you to other health care professionals and facilities.

For Payment. **Dr. Tripp Puhl DC, CCSP** may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you, your insurance policy holder, or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. **Dr. Tripp Puhl DC, CCSP** may use your information to contact you about account balances or to access financial assistance programs for you that may help to defray the costs associated with your care or treatment.

For Health Care Operations. **Dr. Tripp Puhl DC, CCSP** may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your case and similar cases;
- Learn how to improve our facilities and services; and
- Determine how to continually improve the quality and effectiveness of the health care we provide.

Required by Law. **Dr. Tripp Puhl DC, CCSP** may use and disclose information about you as required by law. For example, **Dr. Tripp Puhl DC, CCSP** may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence; and
- To assist law enforcement officials in their law enforcement duties.

Appointment Reminders and Treatment Calls. **Dr. Tripp Puhl DC, CCSP** or his assistants may contact you to provide appointment reminders or information about treatment plans, medication or test results, other health-related benefits and services that may be of interest to you. When contacts are made via telephone, messages will be left on answering machines with limited information.

Notification. **Dr. Tripp Puhl DC, CCSP** may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, you location, and general condition.

Communication with Family. **Dr. Tripp Puhl DC, CCSP** and staff members, exercising their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Miscellaneous Communications. **Dr. Tripp Puhl DC, CCSP** may occasionally use your information to send you greeting cards, notices or other written communications. We may also use your information to identify candidates for focus groups to improve the quality of service for our patients.

Business Associates. In some cases, **Dr. Tripp Puhl DC, CCSP** contracts with business associates to provide services on its behalf. An example includes arrangements with business associates and **Dr. Tripp Puhl DC, CCSP** to provide collection or research services. **Dr. Tripp Puhl DC, CCSP** may disclose your health information to such a business associate so that they can perform their respective job functions. To protect your health information, however, **Dr. Tripp Puhl DC, CCSP** requires the business associate to safeguard your information.

Public Health. Your health information may be used or disclosed for public health activities such as assisting public heath authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.
Decedents. Health Information my be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Research. **Dr. Tripp Puhl DC, CCSP** may use your health information for research studies when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research. **Dr. Tripp Puhl DC, CCSP** use information to identify qualified candidates for research. **Dr. Tripp Puhl DC, CCSP** may use information to make contact with you to determine your interest in the research study/clinical trials.

Physician Board Certification. **Dr. Tripp Puhl DC, CCSP** may use your health information to submit to the Professional Certification Board for purposes required for physicians' qualification to complete their specialty board examination.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Food and Drug Administration (FDA). **Dr. Tripp Puhl DC, CCSP** may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Government Functions. Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Workers Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Other Uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent **Dr. Tripp Puhl DC, CCSP** has taken action in reliance on such.

Your Health Information Rights

You have the right to:

- Request a restriction on certain uses and disclosures or your information; however, **Dr. Tripp Puhl DC, CCSP** is not required to agree to a requested restriction;
- Obtain a paper copy of the notice of privacy practices upon request;
- Inspect and obtain a copy of your health record;
- Request that your health record be amended;
- Request communications of your health information by alternative means or at alternative locations; and
- Receive an accounting of disclosures made of your health information.

Complaints

You may complain to **Dr. Tripp Puhl DC, CCSP** and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of Dr. Tripp Puhl DC, CCSP

Dr. Tripp Puhl DC, CCSP is required to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.

Dr. Tripp Puhl DC, CCSP reserves the right to change its privacy practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you upon your request at your next visit to our practice.

Contact Information

If you have any questions or complaints, please contact:

Dr. Tripp Puhl DC, CCSP 332 West Sunset #8 San Antonio, TX 78209 210-828-2665
Effective November 28, 2006
I acknowledge that I received the Notice of Privacy Practices.

____ ______________________
Signature of Patient or Legal Representative Date

____ ______________________
Printed Name of Patient or Legal Representative Relationship to Patient