PATIENT REGISTRATION AND HISTORY

FOR OFFICE USE ONLY:

HIPAA FORM (YOUR HEALTH INFORMATION RIGHTS):

Cape Integrative Health has designated a Privacy Specialist to answer questions regarding our Privacy Practices as well as to respond to information requests or complaints. You may contact the Privacy Specialist by calling us at 207.799.9950. For inquiries that require a written request, please address them to: Cape Integrative Health 8-10 Hill Way Cape Elizabeth, ME 04107. Attention: Privacy Specialist

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION (PHI):

- *OBTAIN A PAPER COPY OF THE NOTICE UPON REQUEST: At any time, you may request a paper copy of the Notice. Even if you have agreed to receive the notice electronically, you are still entitled to a paper copy, you may request one in person or by contacting the Privacy Specialist.*
- *REQUEST A RESTRICTION ON CERTAIN USES AND DISCLOSURES OF YOUR PHI. You have the right to request additional restrictions on our use or disclosure of your PHI by sending a written request to our Privacy Specialist (address listed above).*
- *INSPECT AND OBTAIN A COPY OF PHI. You have the right to review and copy your PHI which will be kept in a designated record setting for as long as legally required by the State of Maine. The "designated record set" usually will include care and billing records. To review or copy your PHI, you must send a written request to our Privacy Specialist (address listed above). We may charge you a reasonable fee for the costs of copying, mailing, or other supplies that are necessary to grant your request. In certain circumstances we may deny your request to review and copy. If you are denied access to your PHI, you may request that the denial be reviewed.*
- *REQUEST AND AMENDMENT OF PHI. If you feel your PHI, that we maintain is incomplete or incorrect, you may request that we amend it. You may request an amendment for as long as we maintain your PHI. To request amendment, you must send a written request to the Privacy Specialist (address listed above). You must include a reason that supports your request. In certain cases, we may deny your request for the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with the decision and we may give you a rebuttal to your statement.*
- *RECEIVE A REPORT OF THE DISCLOSURE OF PHI. You have the right to receive a report of the disclosures we have made to your PHI. The report will exclude disclosures we have made directly to you, disclosures to friends or family members involved in your care, and disclosure for notification purposes. The right to receive a report is subject to certain other exceptions, restrictions, and limitations. To request a report, you must submit your request in writing to our Privacy Specialist (address listed above). Your request must specify the time period but may not be longer than six years. The first report you request within a 12-month period will be free of charge, but you may be charged for the cost of providing additional reports thereafter. We will notify you of the cost involved and you may choose to withdraw or modify your request at any time.*

(continued on next page)

PATIENT REGISTRATION AND HISTORY

FOR OFFICE USE ONLY:

(continued from previous page)

- *REQUEST COMMUNICATIONS OF PHI BY ALTERNATIVE MEANS OR ALTERNATIVE LOCATIONS. For instance, you may request that we contact you about Health matters only in writing or at a different residence or post office box. To request a confidential communication of PHI about you, you must submit your request to the Privacy Specialist (address listed above). You request must state how or when you would like to be contacted. We will accommodate all reasonable requests.*

FOR MORE INFORMATION OR TO REPORT A PROBLEM If you have questions or would like additional information about the Clinic's Privacy Practices, you may contact our Privacy Specialist at 207.799.9950 or send an e-mail to info@capeintegrativehealth.com. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Specialist or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint. By signing below, I acknowledge that I have received a paper copy of this Notice of Privacy Practices. I have read this notice and had an opportunity to ask questions regarding all of the above listed Privacy Practices.

_____ _____

Patient/Patient Representative's Signature *Date of Signature*

_____

Patient/Patient Representative's Name (Printed)

PATIENT REGISTRATION AND HISTORY

FOR OFFICE USE ONLY:

AUTHORIZATION & CONSENT FOR TREATMENT:

I hereby request and consent to the administration of treatment at Cape Integrative Health, including (but not limited to): primary care, chiropractic adjustments and procedures, various modes of physical therapy, various modes of acupuncture, and if necessary, diagnostic x-rays and blood work for myself (or for the patient named here for whom I am legally responsible: _____) by the attending provider and/or anyone working in this office authorized by the provider.

I further understand that such services may be performed by providers and authorized employees of Cape Integrative Health who may treat me now or in the future at this office. I have had an opportunity to discuss the mentioned procedures with a staff member of Cape Integrative Health and understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, various procedures may carry some rare risks to treatment. Those risks include but are not limited to: fractures, disc injuries, strokes (CVA), dislocations, pneumothorax, bruising, bleeding, and sprains. Further, I wish to rely on the provider to exercise judgment during the course of treatment which the provider feels are in my best interests at this time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by the provider. I intend this consent form to cover the entire course of treatment at this facility for my present condition(s) and for any condition(s) for which I will seek treatment in the future.

_____ _____

Patient/Patient Representative's Signature *Date of Signature*

_____

Patient/Patient Representative's Name (Printed)

PATIENT REGISTRATION AND HISTORY

FOR OFFICE USE ONLY:

CONSENT TO TREAT A MINOR:

I/we, the undersigned parent(s)/person(s), having legal custody/legal guardianship of_____, a minor, do hereby authorize Cape Integrative Health as agent(s) for the undersigned to consent to: any x-ray examination, blood work, chiropractic diagnosis/treatment, acupuncture diagnosis/treatment and/or physical therapy diagnosis/treatment, which is deemed advisable and administered under the general or special supervision of any Cape Integrative Health authorized primary care provider, licensed chiropractor, licensed acupuncturist or licensed physical therapist.

It is understood that this authorization is given in advance of any specific diagnoses or treatments being required but that such authorization is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnoses and treatments which the primary care provider, chiropractor, acupuncturist and/or physical therapist meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

Date: _____

Signature:_____

(parent/legal guardian/person having legal custody)

Signature: _____

(parent/legal guardian/person having legal custody)

FOR OFFICE USE ONLY:

CANCELLATION POLICY

Your appointment is very important to all members of the Cape Integrative Health Team. The time allocated for your appointment has been set aside just for you.

We understand that events might arise resulting in the need to cancel or reschedule an appointment. If it becomes necessary to reschedule or cancel an existing appointment, we request that you provide the office with at least 24 hours notice. This will allow us time to potentially schedule another patient in that time slot.

For no-shows or cancellations taking place less than 24 hours from the time of an appointment, there will be a $95 fee assessed to the patient.

All Monday appointments must be cancelled by the prior Friday as the Office will be closed on the weekends.

By signing below, you acknowledge our cancellation policy and agree to abide by it. Thank you!

_____ _____

Patient Signature *Date*

PATIENT REGISTRATION AND HISTORY

FOR OFFICE USE ONLY:

TODAY'S DATE:_____

PATIENT INFORMATION

Last Name_____ **First Name**_____ **M.I.**_____

Address _____

City _____ **State** _____ **Zip**_____

E-mail _____

Cell Phone _____ **Home Phone**_____

Sex/Gender (choose one) □ *Male* □ *Female* □ *Other* **Age**_____ **D.O.B.**_____

Height _____ **Weight** _____

Your Occupation _____

Employer/School _____

Employer/School Address _____

Hobbies/Interests _____

_____

Dietary Restrictions, if any: _____

Does your diet include: □ *Gluten* □ *Sugar* □ *Dairy*

If Married/Partnered, Spouse/Partner's Name _____

If Married/Partnered, Spouse/Partner's D.O.B. _____

If Married/Partnered, Spouse/Partner's Employer _____

Emergency Contact: _____ **Relationship:** _____

Emergency Contact Phone Number: _____

PATIENT PHONE PERMISSIONS

Please indicate what information we may leave on your cell phone's voicemail:

□ *Detailed messages regarding appointments, medical treatment, care, test results, or financial information*

□ *Only general messages regarding appointments (confirmations or cancellations)*

PATIENT REGISTRATION AND HISTORY

FOR OFFICE USE ONLY:

REFERRAL INFORMATION

How were you directed to Cape Integrative Health?

☐ *Doctor Referral* ☐ *Friend/Family Member* ☐ *Internet Search* ☐ *Radio - which station(s)?* _____

Other: _____

PRIMARY CARE PROVIDER AND/OR OTHER PROVIDERS

Name _____

Address/Practice Location_____Phone#(___)_____

Name _____

Address/Practice Location_____Phone#(___)_____

Name _____

Address/Practice Location_____Phone#(___)_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Cape Integrative Health to release my records and any information requested to the following individuals:

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

4._____ Relation to Patient:_____

PATIENT REGISTRATION AND HISTORY

FOR OFFICE USE ONLY:

PRIMARY INSURANCE INFORMATION

Insurance Provider _____

Member ID # _____ **Group #** _____

Who is responsible for/the subscriber of the account? (circle one) *Self* *Spouse* *Parent*

Name of Subscriber (if other than "Self") _____

D.O.B. of Subscriber (if other than "Self") _____

SECONDARY INSURANCE INFORMATION (Leave blank if not applicable)

Who is the account Subscriber? (circle one) *Self* *Spouse* *Parent*

Name of Subscriber (if other than "Self") _____

D.O.B. of Subscriber (if other than "Self") _____

Insurance Provider _____

Member ID # _____ **Group #** _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage through the above-named insurer, and assign directly to (NAME OF PROVIDER WHOM YOU ARE SEEING) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named provider may use my health care information and may disclose such information to the above-named Insurance Provider(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date provided below:

_____ _____

Print Name of Patient/Guardian/Personal Representative *Signature of Patient/Guardian/Personal Representative*

_____ _____

If not Patient, please note relationship to Patient *Date Signed by/for Patient*

PATIENT REGISTRATION AND HISTORY

FOR OFFICE USE ONLY:

PATIENT CONDITION

Health Goals _____

_____

Reason for Visit _____

When did your symptoms appear? _____ Is this condition getting worse? ☐ *Yes* ☐ *No* ☐ *Unknown*

Have you previously had any imaging done? ☐ *Yes* ☐ *No*

If yes, where was the imaging done? _____

If yes, approximately what date? _____

What was performed? ☐ *X-Ray* ☐ *MRI* ☐ *CT-Scan*

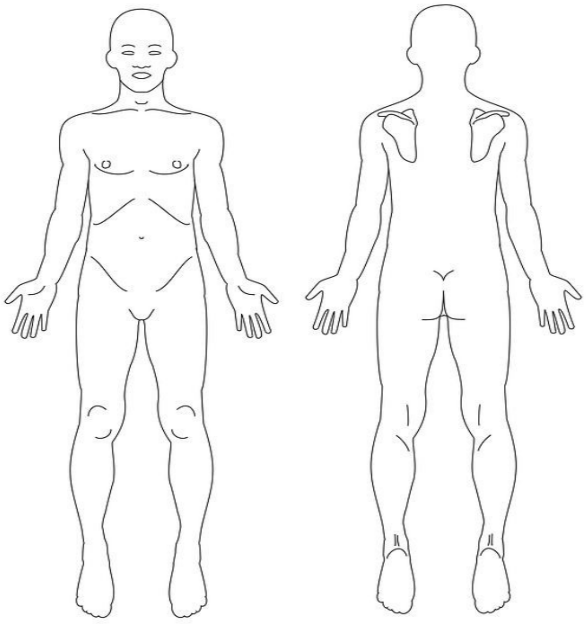
Please provide our office with copies of your imaging and/or reports pertinent to your complaint. We ask that you provide this information before or on the day of your initial visit.

CAUSATION

Is the condition due to an accident? ☐ *Yes* ☐ *No* If yes, when did the accident occur? _____

Type of Accident ☐ *Auto* ☐ *Work* ☐ *Home* ☐ *Other* _____

Mark an "X" on the picture where you continue to have pain, numbness, or tingling:



Type of Pain:

☐ *Sharp*	☐ *Burning*
☐ *Dull*	☐ *Tingling*
☐ *Throbbing*	☐ *Cramps*
☐ *Numbness*	☐ *Stiffness*
☐ *Aching*	☐ *Swelling*
☐ *Shooting*	☐ *Other*

Rate your pain, 0 – 10: _____

PATIENT REGISTRATION AND HISTORY

FOR OFFICE USE ONLY:

What treatment have you already received for your condition?

☐ *Surgery* ☐ *Physical Therapy* ☐ *Chiropractic Services* ☐ *None*

☐ *Other* _____

Name and address of the provider(s) who previously treated you for your condition:

_____

Date of Last:

Physical Exam: _____ *Blood Test:* _____

Spinal Exam: _____ *Urine Test:* _____

Dental Exam: _____ *Eye Exam:* _____ *Bone Scan:* _____

Please indicate if you have experienced any of the following:

☐ AIDS/HIV	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Typhoid Fever
☐ Alcoholism	☐ Dementia	☐ IBS	☐ Polio	☐ Ulcers
☐ Allergy Shots	☐ Emphysema	☐ Irregular Heartbeat	☐ Prostate	☐ Ulcerative Colitis
☐ Anemia	☐ Epilepsy	☐ Kidney Disease	☐ Prosthesis	☐ Vaginal Infection
☐ Anorexia	☐ Fractures	☐ Liver Disease	☐ Psychological Care	☐ Whooping Cough
☐ Appendicitis	☐ Gerd	☐ Measles	☐ Rheumatoid Arthr.	☐ Other
☐ Arthritis	☐ Glaucoma	☐ Mental Health Issues	☐ Rheumatic Fever	_____
☐ Asthma	☐ Goiter	☐ Migraines	☐ Scarlet Fever	_____
☐ Bleeding Disorder	☐ Gout	☐ Miscarriage	☐ Seizures	_____
☐ Breast Lump	☐ Heart Attack	☐ Mononucleosis	☐ STD	_____
☐ Bronchitis	☐ Heart Disease	☐ Multiple Sclerosis	☐ Stroke	_____
☐ Bulimia	☐ Hepatitis	☐ Mumps	☐ Suicide Attempt	_____
☐ Cancer	☐ Hernia	☐ Osteoporosis	☐ Thyroid	
☐ Cataracts	☐ Herniated Disc	☐ Pacemaker	☐ Tonsillitis	
☐ Chemical Dependency	☐ Herpes	☐ Parkinson's	☐ Tuberculosis	
☐ Chicken Pox	☐ High Blood Pressure	☐ Pinched Nerve	☐ Tumors/Growths	

Exercise: ☐ *None* ☐ *Moderate* ☐ *Daily* ☐ *Heavy*

Exercise Activity: _____

Work Activity: ☐ *Sitting* ☐ *Standing* ☐ *Light Labor* ☐ *Heavy Labor*

Habits: ☐ *Smoking, ___ packs/day* ☐ *Alcohol, ____drinks/week* ☐ *Coffee/Caffeine, ____cups/day*
☐ *Vaping/e-Cigarettes* ☐ *Cannabis*

PATIENT REGISTRATION AND HISTORY

FOR OFFICE USE ONLY:

Are you pregnant? □ *Yes* □ *No* *If yes, Due Date* _____

Date of most recent mammogram _____**Date of first day of most recent menses** _____ □ *Regular* □ *Irregular*

Menses occurs how many days on average? _____ **Date of last pap smear** _____

Number of pregnancies _____ **Number of vaginal deliveries** _____

Describe any Hospitalizations/Surgeries you have had, and when: _____

_____

_____

Please describe any medications you are currently taking, and the dosage:

Medication Name	Dosage (if known)

Please describe any allergies from which you suffer, categorized by type:

Drug	Food	Environmental

Who is your preferred pharmacy? _____

FAMILY HISTORY

Please indicate if an immediate family member has any history of the following conditions. If a box is checked, please also note to whom the condition is related with F (father), M (mother), S (sister), B (Brother), GF (grandfather) or GM (grandmother)

□ Asthma	□ Heart Attack	□ Kidney Disease	□ Parkinson's	□ Thyroid Problems
□ Cancer	□ Heart Disease	□ Liver Disease	□ Rheumatoid Arthr.	□ Other
□ Dementia	□ High Blood Pressure	□ Miscarriage	□ Seizures	□ _____
□ Diabetes	□ High Cholesterol	□ Osteoporosis	□ Stroke	□ _____

OR: □ *Unknown family history due to adoption*