JOSEPH J DAY DC, INC.

Patient Name _____ Birthdate _____ Sex: M / F

Address _____ City _____

State _____ Zip _____ Phone (____) _____ Cell (____) _____

Occupation _____ Employer _____ Work Phone _____

Email _____ Status: Single, Married or Divorced

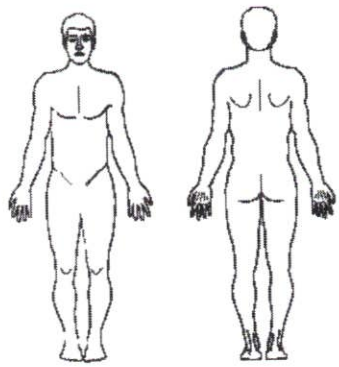
SS# _____ Insurance Health Plan _____

Subscriber's name: _____ Subscriber ID # _____ Group # _____

Emergency Contact _____ Phone # _____ Zip _____

Primary Physician Name: _____ Phone _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain

☐ Other _____

Is this? ☐ Work Related ☐ Auto Related ☐ Other _____

Date of accident _____

How Problem Began _____

Current complaint (how you feel today):

_____

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present?

☐Occasional (0-25%) ☐ 25-50% ☐ 50-75% ☐ 75-100% Constant

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

_____

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general, would you say your overall health right now is:

Excellent Very Good Good Fair Poor

HAVE YOU HAD X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? No ☐ Yes ☐

Date(s) taken _____ **What areas were taken?** _____

Please check all the following that apply to you:

__Alcohol/Drug Dependence
__Recent Fever
__Diabetes
__High Blood Pressure
__Stroke (Date) _____
__Corticosteroid Use (Cortisone, Prednisone, etc.)
__Taking Birth Control Pills
__Dizziness/Fainting
__Numbness in Groin/Buttocks
__Cancer/Tumor(Explain)_____
_____
__Osteoporosis __Epilepsy/Seizures
Other Health Problems (Explain)_____

__Prostate Issues
__Menstrual Problems
__Urinary Problems
__Currently Pregnant, # Weeks_____
__Abnormal Weight Gain Loss
__Marked Morning Pain/Stiffness
__Pain Unrelieved by Position
__Pain at Night
__Visual Disturbances
__Surgeries_____
__Tobacco Use - Frequency _____ /Day
__Medications_____
_____

Family History:

___Stroke/Heart Problems ___ Diabetes ___High Blood Pressure __Cancer ___ Rheumatoid Arthritis

I certify to the best of my knowledge; the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary. Certain insurances such as HMO's (including ASHN/ASHP or Landmark) do not cover the following therapies: DTS (97799), Laser(99979) and Massage(97124), therefore I acknowledge that I will be financially responsible for payment if these therapies are included in my treatment

Patient Signature _____ **Date** _____

JOSEPH J DAY DC, INC.
NOTICE OF PRIVACY PRACTICES

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.

Joseph J Day DC, Inc., is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals with our practice for the purpose of treatment, payment or healthcare operations via fax, email or any preferred method of communication.

On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Joseph J Day DC, Inc.

It is our policy to provide a substitute health care provider, authorized by Joseph J Day DC, Inc. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation.

There may be incidental disclosure of health care information due to the 'open' layout of our office. Although we still require patients to sign in, no protected health care information will be listed on the sign in sheet. We ask that you remain aware that some treatment areas are open; should you have the need to discuss information that requires additional privacy or are uncomfortable with the openness in the treatment area you are in, please let the doctor of staff know and we will accommodate you with a closed-door room.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

As a courtesy to our patients, we will submit and itemized billing statement to your insurance carrier for the purpose of payment to Joseph J Day DC, Inc. for health care services rendered. If you pay for your health care services personally, we will as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.

Our filing system is in an "employee only" area of the office and labels on files identify patients by name only. Patients are asked to be respectful of the "employee only" areas of the office.

Workers' Compensation
We may disclose your health care information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition in the event of an emergency or of your death.

Public Health
As required by law we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence to the Food and Drug Administration problems with products and relations to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative of judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing
We may contact you for marketing purposes or fundraising purpose, as described below:
(Example)

As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. NO personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Joseph J Day DC, Inc. sponsored fund-raising events.

Change of Ownership
In the event that Joseph J Day DC, Inc. is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Right

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Joseph J Day DC, Inc. is not required to agree to the restrictions that you requested.

You have the right to have health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have the right to request that Joseph J Day DC, Inc. amend your protected health information. Please be advised, however, that Joseph J Day DC, Inc. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have the right to receive an accounting of disclosures of your protected health information made by Joseph J Day DC, Inc.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Joseph J Day DC, Inc. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Joseph J Day DC, Inc. is required by law to comply with this notice.

Joseph J Day DC, Inc. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Dr. Day by calling our office at (775) 853-3343. If Dr. Day is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

I have read the Joseph J Day DC, Inc. 3 page Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Joseph J Day DC, Inc. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____ ____/____/_____
Patient's Signature Date

_____ ____/____/_____
Authorized Facility Signature Date

Complaints
Complaints about your Privacy Rights or how Joseph J Day DC, Inc. has handled your health information should be directed to Dr. Day by calling our office at (775) 853-3343. If Dr. Day is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of 01/01/2021

INFORMED CONSENT DOCUMENT

To the patient: please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment. The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experience when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment. As a part of the analysis, examination, and treatment, you are consenting to the following procedures

***spinal manipulative therapy**	***palpation**	***vital signs**	***orthopedic testing**
***range of motion testing**	***postural analysis**	***ultrasound**	***basic neurological testing**
***muscle strength testing**	***hot/cold therapy**	***massage**	***electrical muscle stimulation**
***traction/decompression (DTS)**	***laser therapy**	***exercise therapy**	

The material risk inherent in chiropractic adjustment. As with any health care procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strength, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bones which I check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in 1 million and one in 5 million cervical adjustments. The other complications are also generally described as rare.

The availability in nature of other treatment options. Other treatment options for your condition may include: Self-administered, over-the-counter analgesics and the rest. Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers. Hospitalization or surgery. If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated. Remaining untreated may allow the formation of adhesions and reduced mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

-I have also read the Joseph J Day Chiropractic, Inc. 2-page Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Joseph J Day Chiropractic, Inc. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

DO NOT SIGN THIS UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of chiropractic adjustment and related treatment. I have discussed with Joseph J Day DC/Christine Epper DC/Shannon Peacock DC and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment to Joseph J Day, DC Inc and any of his staff.

_____ _____

Patient's Name Date

_____

Patient's Signature (or Parent or Guardian if a minor)

Joseph J Day DC/Christine Epper DC/Shannon Peacock DC_____

Doctor's Name Date

_____

Witness