

Please complete the following pages.

You can postal mail the completed application to:

**Physicians First, Inc.
1438 S.O.M. Center Road
Mayfield Heights, OH 44214
Attn: Application for Treatment**

**Or you can fax it to us at:
440.461-5548**

Or you can bring it with you on your first appointment.

Thank You!

APPLICATION FOR TREATMENT

Protected Health Information (PHI)

PATIENT INFORMATION	Your Name _____	Date of Birth _____	Age _____
	Address _____	Sex _____	
	City, State, Zip _____	Social Security # _____	
	Home Phone _____	Work Phone _____	
	Cell Phone (Opt.) _____	No. of Children _____	
	Your Occupation _____	Employer Name _____	
	Employer Address _____	City, State, Zip _____	
	Spouse's Name _____	Work Phone _____	
	Nearest Relative _____	Phone _____	

PRESENT COMPLAINT	Describe Your Problem _____	
	Doctors Seen for This Problem _____	Work Days Missed _____
	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	How Many Days? _____

MEDICAL HISTORY	<input type="checkbox"/> Polio	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Numbness	<input type="checkbox"/> Nervousness	<input type="checkbox"/> German Measles	<input type="checkbox"/> High Blood Pressure
	<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Backaches	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Muscular Dystrophy
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Cancer	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Concussion	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Multiple Sclerosis	
	<input type="checkbox"/> Neuritis	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Digestive Disorders	

PREVIOUS CARE	Previous Surgeries _____	When? _____
	Have you seen a physician for any reason or condition in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Describe Reason or Condition _____	
	Allergic to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	What Kind? _____
	Currently taking medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	What Kind? _____
	Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Period? _____

INSURANCE INFORMATION	Insured Name _____	Phone _____
	Insured Address _____	
	Insurance 1 Name _____	Policy No. _____
	Insurance 1 Address _____	Group No. _____
	Insurance 2 Name _____	Policy No. _____
	Insurance 2 Address _____	Group No. _____
	Spouse's Insurance Name _____	Policy No. _____
	Address _____	Group No. _____
	Workers' Comp? <input type="checkbox"/> Yes <input type="checkbox"/> No	Group No. _____
	Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare No. _____

PATIENT AGREEMENT	I authorize Physicians First, Inc./Gallucci Chiropractic Clinic (the "practice") to furnish Protected Health Information (PHI) to the identified insurance carrier(s) for any and all payment activities. I further consent to the use of my PHI for any operational needs of this practice, as identified in the Notice of Privacy Practices.	
	I consent to assign to this practice all payments for services provided by this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract(s) with my insurance carrier(s) and state regulation. I further understand that my contract(s) with my insurance carrier(s) may not cover some services, and that if I seek care outside of the contract, I will be responsible for all charges that are incurred for services provided by this practice. I also understand that, although this practice may assist me, it is ultimately my responsibility to obtain information from my health insurance carrier(s) regarding coverage.	
	Patient (or Responsible Party) Signature _____	Date _____

PLEASE TELL US	Do you have a preference as to which doctor you see? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who? _____
	Do you wish to have a third person or chaperon present during your exam and treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Is your visit due to an accident or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the other side of this form.

ACCIDENT/INJURY REPORT

GENERAL INFORMATION	Day and Date of Accident/Injury _____	Time of Accident/Injury _____	<input type="checkbox"/> AM <input type="checkbox"/> PM
	Type of Accident/Injury <input type="checkbox"/> Work Related <input type="checkbox"/> Traffic <input type="checkbox"/> Other	Number of Days Missed From Work _____	

WORK-RELATED ACCIDENT	Employer _____	Type of Business _____
	Were any equipment, machinery, or other objects related to the accident/injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, please describe _____	
	Was accident reported to a Supervisor and/or Employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has a Workers' Compensation claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe the accident/injury, including cause(s) and surrounding circumstances _____		

TRAFFIC ACCIDENT	What type of vehicle was involved in the accident? <input type="checkbox"/> Truck <input type="checkbox"/> Car <input type="checkbox"/> Motorcycle <input type="checkbox"/> Other	Were you a <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian?	If a passenger, where? <input type="checkbox"/> Front Seat <input type="checkbox"/> Back Seat <input type="checkbox"/> Other	
	Was your vehicle moving at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did your vehicle hit other vehicle(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	MPH? _____	Where? _____
	Did other vehicle(s) hit your vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	Approximately how much damage (in dollars) was done to your vehicle? \$ _____	Was this accident reported to the Police? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Were traffic citations issued? <input type="checkbox"/> Yes <input type="checkbox"/> No		To whom? _____	
	Describe the accident/injury, including cause(s) and surrounding circumstances _____			

PRESENT COMPLAINT	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Pain Behind Eyes	<input type="checkbox"/> Excess Perspiration	<input type="checkbox"/> Neck Restricted	
	<input type="checkbox"/> Tension	<input type="checkbox"/> Headache	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Feet/Hands Cold	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Low-back Pain/Stiff	
	<input type="checkbox"/> Neuritis	<input type="checkbox"/> Face Pale	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Nausea, Vomiting	<input type="checkbox"/> Ears Buzz/Ring	<input type="checkbox"/> Upper-back Pain/Stiff	
	<input type="checkbox"/> Fainting	<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Face Flushed	<input type="checkbox"/> Extreme Fatigue	<input type="checkbox"/> Equilibrium Problem	<input type="checkbox"/> Pins & Needles	
	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Mental Dullness	<input type="checkbox"/> Head Seems Heavy	<input type="checkbox"/> Shoulders Tired	
	<input type="checkbox"/> Tremors	<input type="checkbox"/> Irritability	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Digestive Trouble	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Extremity Numbness	
	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Palpitation	<input type="checkbox"/> Neck Stiffness	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Eyes Light Sensitive	<input type="checkbox"/> Swollen Areas: _____	
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Depression	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Mid-back Pain/Stiff		
	<input type="checkbox"/> Difficulty in excessive: <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Riding <input type="checkbox"/> Bending						
	<input type="checkbox"/> Neck and low back pain and stiffness upon rising						
<input type="checkbox"/> Pain radiating into: <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Leg <input type="checkbox"/> Left Leg <input type="checkbox"/> Left Arm <input type="checkbox"/> Neck <input type="checkbox"/> Shoulders <input type="checkbox"/> Hips <input type="checkbox"/> Skull							
<input type="checkbox"/> Difficulty in Lifting: <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Only if Repetitive							
Did you require post-accident hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, where? _____			
Have you had similar accidents/injuries before? <input type="checkbox"/> Yes <input type="checkbox"/> No							
<input type="checkbox"/> Any symptoms in addition to, or other than those checked above? _____							

INSURANCE INFORMATION	Insurance Company of Responsible Party _____	Claim Number _____
	Have you been contacted by an insurance adjuster or representative about claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have an attorney advising you in this case? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, Attorney Name _____	
Attorney Address _____		
Attorney Phone _____		

PATIENT SIGNATURE	I hereby attest that all of the above is true and accurate to the best of my knowledge and ability to recall the accident/injury.	
	Patient Signature _____	Date _____

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.

This is a formal notification, as required by the Federal government's "HIPAA Privacy Rule" concerning the privacy policy of this practice. This practice has an obligation to maintain all medical information in the strictest of confidence as required by law. Our practice cannot release information about you without your written consent, including medical records, conversations, reminder calls, test results and other information that may be of a confidential nature. Patient information about health care is identified as "PHI" or Protected Health Information.

This policy, effective April 14, 2003, requires that you, the patient, identify and clarify at the time of registration with this practice who we can talk to and how we can communicate health information on your behalf. **You can change your requests at any time with either written notification or verbal notification, followed up in writing.** Changes can only impact the care of information from that point in time forward.

Your Protected Health Information (PHI) is an integral part of your medical care, and can be used or disclosed with your written consent as follows:

- ***For your treatment*** in this practice and other locations under the physicians' immediate care. This may include medical assessment, diagnostic testing, treatments, and procedures, as well as coordination with other physicians involved with your care, referrals, and related care needs.
- ***For obtaining payment*** for treatment with your identified insurance carrier or health coverage program. This may involve any documentation related to your care, including history forms, progress notes, test results, and procedure notes. This would include eligibility verification, prior authorization, and claim submission.
- ***For operations*** of this practice, such as enrolling with insurance programs, Quality Control programs, accounting, and compliance with federal and state laws and regulations.
- Appointment reminders and health-related benefit services.
- Disclosure to your family and friends concerning any related health information.
- **Consent is not required for emergency care and treatment.** An emergency is identified as a medical condition that in the judgment of the physician requires immediate and full disclosure of information for care on your behalf.

Certain disclosures can be made without your consent, and they are as follows:

- Disclosure required by government or law enforcement agencies. Specific areas that require release include domestic violence and victims of abuse or neglect.
- Information used for public health purposes, medical examiners, or related to a person's

death, or for the health department for disease tracking.

- Information used for health care oversight, such as a site review by an insurance program.
- Information provided to avoid harm upon threat to patient or public safety.
- Workers' Compensation programs.

Your rights for your health information include:

- The right to request limits on the uses and disclosure at registration or any time during your care.
- The right to choose how we send this information to you, including an alternate address.
- The right to see and obtain copies of your PHI, but there may be a fee.
- The right to get a listing of who we have made disclosures to about your PHI.
- The right to correct your file, if appropriate, through an amendment process.

This practice reserves the right to modify or change this Notice of Privacy Practices and related processes at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Notice. An updated Notice will be posted in the office within 60 days of the revision.

If you have a concern or complaint about how your PHI is being used, you should first contact our HIPAA Coordinator/Privacy Officer at our Mayfield Heights office to resolve your concerns. If you are not satisfied with the results, you may report this practice to:

*Office of Civil Rights - Regional Manager
Department of Health & Human Services
233 N. Michigan Avenue, Suite 240
Chicago, Illinois 60601*

*GBA Palmetto - Medicare Intermediary
Part B Operations-HIPAA Compliance Concerns
P.O. Box 18957
Columbus, Ohio 43218*

Patient Name (Printed)	
Patient Signature Upon Receipt of this Notice:	Date signed:
Signature of Patient Representative (If Patient is Unable to Sign):	Date signed:
Relationship to Patient:	Reason:
Patient Refuses to Sign - Signature of Witness:	Date signed:

Physicians First, Inc. / Gallucci Chiropractic Clinic

PATIENT ACKNOWLEDGMENT AND CONSENT

This consent is required by the Federal government's Health Insurance Portability and Accountability Act of 1996 (HIPAA) to inform you of your rights for privacy with respect to your Protected Health Information (PHI).

Consent for treatment: I authorize this practice, and any employee working under the direction of the physician(s) of this practice, to provide medical care for me, or to this patient which I represent. This medical care may include services and supplies related to my (or the identified person's) health and may include (but not limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, and/or palliative care; counseling, assessment or review of physical status/function of the body; and/or the sale or dispensing of drugs, devices, equipment, or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for purposes of furthering care and treatment.

Consent for release of information for payment and operations: I authorize this practice to furnish PHI to the identified insurance carrier(s) for any and all payment activities. I further consent to the use of my PHI for any operational needs of this practice, as identified in the Notice of Privacy Practices. This release may include information about drug use/abuse, alcohol use/abuse, mental health issues or concerns, AIDS or HIV status as pertinent to my medical care.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract(s) with my insurance carrier(s) and state regulation. I further understand that my contract(s) with my insurance carrier(s) may not cover some services, and that if I seek care outside of the contract, I will be responsible for all charges that are incurred for services provided by this practice. I also understand that, although this practice may assist me, it is ultimately my responsibility to obtain information from my health insurance carrier(s) regarding coverage.

Consent related to the Notice of Privacy Practices: I have had a chance to review this practice's Notice of Privacy Practices as part of this registration process. I understand that the terms of that Notice of Privacy Practices may change, and that I may obtain these revised notices by contacting the practice by telephone or in writing. I understand that I have the right to request how my Protected Health Information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If I do choose to impose disclosure restrictions, I will complete and sign a Restrictions to Consent of Discloser of PHI form provided to me by this practice. I understand that if this practice does agree to my restrictions on PHI use, it is bound by that agreement.

I hereby give my consent to Physicians First, Inc./Gallucci Chiropractic Clinic to use and disclose my Protected Health Information (PHI) for the purposes of treatment, payment, and practice operations.

Patient Name (Printed)	
Patient Signature:	Date:
Notice of Privacy Practices executed on (Date):	
Signature of Patient Representative (If Patient is Unable to Sign):	Date:
Relationship to Patient:	Reason:
Patient Refuses to Sign - Signature of Witness:	Date:

Revocation: I have the right to revoke this consent at any time. If I revoke this consent, I understand that the revocation will only apply to disclosures of PHI from the date of revocation forward. **I hereby revoke the consent given above:**

Patient Signature:	Date:
Signature of Patient Representative (If Patient is Unable to Sign):	Date:
Relationship to Patient:	Reason:

HELP US HELP YOU!

Communication is an important part of any doctor-patient relationship. As a patient in our office, we need to know how you want us to communicate important information regarding your treatment when you are not here in the office.

Also, by providing us the following information, you will be helping us to safeguard the privacy of your Protected Health Information (PHI), as defined by the Federal government's Health Insurance Portability and Accountability Act of 1996 (HIPAA).

How did you decide to come to our clinic? _____

Were you referred by someone? Yes No Who? _____

Family/Primary Care Doctor: _____ Location: _____

May we share information regarding your condition and/or treatment with this doctor? Yes No

E-mail Address: _____

May we send you healthcare information at your e-mail address? Yes No

At which of the telephone numbers you provided would you prefer to be contacted?

Home Cellular Work

If you are not available, may we leave a message to call us on your answering system? Yes No

If you are not available, may we leave a message to call us with any other person? Yes No

Who? List all that apply: _____

Is there anyone else to whom we may disclose your Protected Health Information? Yes No

Who? List all that apply: _____

Patient Name (Printed)

Patient Signature: _____

Date: _____

Signature of Patient Representative
(If Patient is Unable to Sign): _____

Date: _____

Relationship to Patient: _____

Reason: _____