Thomas DeSalvo DC INC
1701 N Seward Meridian Pkwy. - Wasilla, AK 996546682
Phone: (907) 357-7463 • Fax: (907) 376-5270

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Preferred Name: _____

Maiden Name: _____ Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

Employer: _____ Occupation: _____

Address: _____ (City, State, Zip): _____

Name: _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Responsible Party's Phone #: _____ Relationship to Patient: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security #: _____ Phone: _____

Insurance Company: _____ Group #: _____ ID Number: _____

Address: _____ (City, State, Zip): _____

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Employer: _____ Employer Phone: _____

Name: _____ Phone: _____ Relationship to Patient: _____

Address: _____ (City, State, Zip): _____

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident (State of Auto Accident) _____

If Employment related, has employer been notified? ☐ Yes ☐ No Employer Contact Name: _____

Employer Contact Phone and Extension: _____

☐ By an Attorney ☐ By a Doctor ☐ By a Patient ☐ Yellow Pages ☐ Other

Please print the name of your source: _____

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Thomas DeSalvo DC INC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____ Date: _____

Thomas J DeSalvo and Konstantine Bunde
1701 N Seward Meridian Parkway
Wasilla, AK 99654

What was your primary complaint?

_____

_____

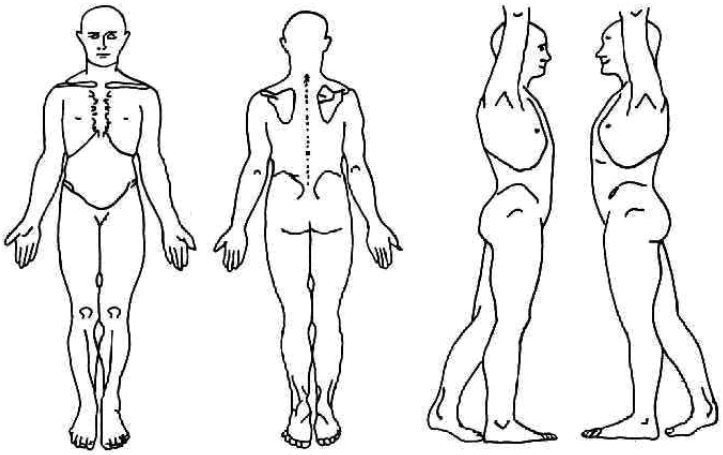
When did the pain start?

_____

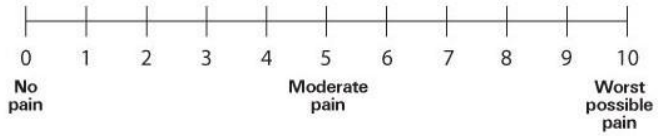
_____

What is causing your pain? Please indicate the area of your symptom(s) using an “X” on the figures below:

_____



What is your current pain level?



Describe the pain at your worst: (i.e.; sharp, achy, dull, throbbing, etc.)

_____

_____

Describe the pain at your best: (i.e.; non-existant, achy, etc.)

_____

_____

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Medical History

Please check all that apply:

__Emphysema
__Tuberculosis
__Pneumonia
__Bronchitis
__Asthma
__Heart Disease
__Stroke
__High Blood Pressure
__Elevated Cholesterol
__Diabetes
__Sexually Transmitted Infections
__Venous Thrombosis
__Hepatitis A
__Hepatitis B
__Hepatitis C
__Cirrhosis
__Anemia
__Gallbladder Disease
__Ulcers
__Frequent Urinary Tract Infections
__Cancer
__Prostate Trouble
__Arthritis
__Osteoporosis
__Fractures
__Migraines
__Depression
__Anxiety or Panic Disorders
__Posttraumatic Stress Disorder
__Alcohol or Substance Use Problem
Other: _____

Systems Review

Please Check any of the following symptoms that you have recently experienced or are a concern to you:

General:		
__Recent weight loss	__Fatigue	__Fever
__Recent weight gain	__Changes in appetite	__Night sweats
Skin:		
__Rashes	__Lumps	__Itching
__Dryness	__Color Changes	__Hair or Nail Change
Head:		
__Headaches	__Head Injuries	__Dizziness
Eyes: Last date of exam: _/_/_		
__Glasses	__Double Vision	__Glaucoma
__Contacts	__Redness	__Cataracts
Nose:		
__Frequent Colds	__Hay Fever	__Sinus Trouble
__Nasal Stuffiness	__Nose bleeds	__Dust/Animal Allergies
Ears:		
__Hearing Loss		

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Mouth & Throat: Date of Last Dental Exam: _/_/_

__Bleeding Gums __Frequent Sore Throats __Hoarseness

Neck:

__Goiter __Lumps/Swollen Glands __Pain

Breasts: Date of the last Mammogram: _/_/_

__Lumps __Pain __Nipple Discharge

Respiratory:

__Cough __Wheezing

__Shortness of Breath __Coughing up Blood

Cardiac:

__Heart Murmur __Chest Pain __Palpitations

__Swelling of Feet __Shortness of Breath

Gastrointestinal:

__Trouble Swallowing __Diarrhea __Hemorrhoids

__Heartburn or Gas __Rectal Bleeding __Jaundice

__Nausea __Abdominal Pain __Vomiting

__Constipation

Urinary:

__Frequent Urination __Painful Urination __Difficulty Urinating

__Stones __Blood in Urine

__Waking up to go to the Bathroom Several Times at Night

Musculoskeletal:

__Joint Stiffness __Arthritis __Gout

__Backache __Muscle Pains __Muscle Cramps

Peripheral Vascular:

__Leg Cramps While Waking __Varicose Veins __Thrombophlebitis

Neurological:

__Fainting __Blackouts __Seizures

__Weakness __Numbness __Tremors

__Tingling is Hands or Feet __Change in Memory

Psychiatric/Psychological:

__Anxiety __Depression __Phobias

__Family Problems __Eating Disorder

Hematologic:

__Anemia __Easily Bruised or Bleeding __Blood Transfusions

Endocrine:

__Heat or Cold Intolerance __Excessive Sweating

__Excessive Hunger __Excessive Urinating

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Have you ever been hit, slapped, kicked, or otherwise physically hurt by someone?

__Yes, in the past year __Yes, prior to this past year __No

Has anyone ever forced you into having any type of sexual activity?

__Yes __No

Do you experience chronic pain?

__Yes __No

If yes, how is your pain managed? (i.e. physical therapy, medication, etc.)

_____

On a scale of 0 to 10, with a 10 being the worst and 0 being the best, how would you rate your current pain?

_____

Operations and/or Hospitalizations: (reasons and dates; if you only know the year that is okay.)

_____

Current Medications: (Please include all non-prescription drugs as well, vitamins, aspirin, etc.)

Medication name:	Dose:	Frequency of use:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

Allergies: (please list any allergies to medication and food)

_____

Family History: Significant illnesses;

Mother _____

Father _____

Brother _____

Sister _____

Family Status:

Number of Children: _____

Ages: _____

Caffeine Use:

__Yes __No

Alcohol Use:

__Social Drinker __Never

Tobacco Use:

__Cigarettes __ Cigars __None

Number of Years: ____

Year Quit: ____

Type of Exercise: _____

__Rarely __Occasionally __Regularly

Education Level:

__ High School Diploma __GED __2 Year Degree __Post Graduate Level __4 Year Degree

Date of Last Physical Exam: __/__/__ **Name of Doctor who performed exam:** _____

HIPAA Notice of Privacy Practices

_____ (Print Name)

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 your rights to access and control your PHI. Protected health information 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.

1. Uses and disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your car and treatment for 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 protected health information 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 to support the business activities of your physicians 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 your 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 be asked to sign your name to indicate your physician that you are checked in. 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 your PHI in the following situations without your authorization. These situations include: as required By law, Public Health Issues as required by law, Communicable Diseases: health Oversight: Abuse or Neglect: Food and Drug Administration 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 Health and Human Services 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 physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

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 complied in reasonable anticipation or, 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 for the purposes of treatment, payment, or healthcare operations. You may also request any part of your PHI not to 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 said 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 the right to use another Healthcare Professional.

You have the right to request t 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 protected health information. If we deny your request for amendment, you have the tight 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 by 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 Health and Human Services if you believe that we have violated your privacy rights. 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 was published and becomes effective on/or before **April 14th, 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 protected health information. 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 Privacy Practices:

Print Name: _____ Signature: _____ Date: ___/___/___

Insurance

Primary Insurance Information:

Insurance Carrier: _____

Policy/ID Number: _____ Group Number: _____

Policy Holders Name: _____ Policy Holders DOB: _____/_____/_____

Policy Holders Relationship to Patient: ___ Self ___ Child ___ Spouse ___ Other

Secondary Insurance Information:

Insurance Carrier: _____

Policy/ID Number: _____ Group Number: _____

Policy Holders Name: _____ Policy Holders DOB: _____/_____/_____

Policy Holders Relationship to Patient: ___ Self ___ Child ___ Spouse ___ Other

Financial Policy/Benefit Assignment

BENEFITS
I authorize payment of medical benefits to my provider. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the release of any information necessary to secure the payment of benefits. I agree that all charges for medical service rendered that are not directly paid by my insurance will be my responsibility. _____ (INITIAL)

INSURANCE
It is the patient's responsibility to provide our practice with current insurance information. Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your claim for you. However, we will not become involved in disputes between you and your insurance carrier. We will supply you with the information as necessary. If your insurance co does not pay within 60 days, you will be held responsible for the timely payment on your account. _____ (INITIAL)

SCREENING PROCEDURES
It is advisable that you, the patient, be fully informed as to what your insurance covers. At your first appointment, prior to scheduling ANY procedures, an exam will be performed here in our office. This office exam is NOT part of the procedure & will be billed to your insurance as a "pre-treatment exam". This exam can be subject to your deductible/co-insurance depending on your particular insurance plan. _____ (INITIAL)

CO-PAYS
All co-pays, co-insurances, & deductibles will be paid at the time of service as required by your insurance contract. If you are unable to pay your co-pays or deductibles in full, payment plans must be made *prior* to your appointment. _____(INITIAL)

SELF-PAY ACCOUNTS
In the event that the total balance due is more than you are able to pay, we will make reasonable payment arrangements. New self-pay patients will be *required* to bring $160.00 to their initial appt. _____(INITIAL)

PAYMENT ARRANGEMENTS
In the event the total balance is more than you are able to pay, we will make reasonable payment plans. Please see the office manager. _____(INITIAL)

COLLECTIONS
In the event that your account goes 3 months without payment, it will be turned over to collections. Please be aware that you will be responsible for all collection & attorney's fees in order to collect on any unpaid debt. _____(INITIAL)

I certify that the above insurance information is true & correct to the best of my knowledge. I also acknowledge that I have read the financial policy.

_____ _____
Patient/Responsible Party Today's Date