BODY OF LIGHT FAMILY CHIROPRACTIC & MASSAGE

396 E. 18th Ave. Eugene, OR 97401 (541) 687-7775

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Welcome! We are honored that you have chosen both massage and our office to help your body reach its optimum health potential. We invite you to breathe, relax and be open to the healing miracles that routinely happen with massage care.

GENERAL INFORMATION:

Full Name: _____ Sex:_____ Age: _____ DOB: _____

Cell/Home #: _____Work#: _____ E-mail: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Occupation: _____

Employer: _____

Whom may we thank for referring you? _____

Our Chiropractic and Massage Principles/Foundation:

- The body is self-healing and self-regulating.
- The nervous system controls the body's ability to function and adapt (heal and regulate).
- Spinal misalignments (vertebral subluxations) cause interference to the nervous system.
- Chiropractors locate and correct vertebral subluxations with specific spinal adjustments.
- Adjustments remove interference to the nervous system and allow the body to heal.
- Massage addresses the soft tissue of the body; often decreasing pain, stress and muscle tension while increasing the body's innate healing ability.

What brings you here today?

_____

Is there any area where you would like extra time spent?

_____

Is there any area where you have muscle pain/stiffness/tension (neck, low back, shoulder, other)?

_____

Can you lie comfortably on your stomach?_____

Can you lie comfortably on your back?_____

What is your previous experience with professional massage?

_____

What is your previous experience with chiropractic care?

_____

Daily activities/sports/hobbies:_____

Present State of Health (Presenting Symptoms) The years of continuing stress/damage may show up as acute or chronic symptoms. If you are seeking massage or chiropractic care because of a specific complaint, please answer the questions below.

Present complaint:

_____

How long have you been experiencing this problem?

_____

Describe symptom (sharp/dull/numb etc.)

_____

Is the symptom: getting better ___ staying the same ___ getting worse ___

Aggravated by?

_____

Helped by?

_____

How much discomfort do you typically experience on a scale of 1 - 10?

_____

How does the symptom(s) interfere with your life? (i.e.: sleep/work/play/lifting children, etc.)

_____

Have you seen other doctors for this condition(s)?

_____

Health Conditions (present or past): (While these symptoms/conditions may seem unrelated to the purpose of the appointment, they may be related to the health/dis-ease of the nervous system).

__asthma	__allergies	__ arrythmia	__ arteriosclerosis	__ arthritis	__blood pressure	__broken bones
__cancer	__cold extremities	__cold sweats	__constipation	__depression	__diabetes	__diarrhea
__dizziness	__ear infections	__epilepsy	__fainting	__fatigue	__headaches	__heart attack
__heart disease	__HIV/AIDS	__irritability	__kidney problems	__loss of sleep	__low back pain	__lymphatic condition
__mid back pain	__neck pain	__nervousness	_numbness	__osteoporosis	__phlebitis	__pins/needles

__previous fracture	__psychiatric issues	__restricted motion	__sinus problems	__skin conditions	__stiff neck	__stress
__stroke	__tension	__thyroid problems	__ulcers/colitis	__varicose veins	__weakness	
For Women:	*__pregnant*	*__birth control*	*__menses pain*	*__irreg cycles*		

Any other health concerns you feel may or may not be related:

_____

Have you been under drug or medical care for any of these conditions?

_____

Please list any medications you are taking and why:

_____

Previous surgeries (please state type and date):

_____

Name of primary care physician:

_____

Do we have permission to contact him/her should the need arise? Yes____ No ____

Financial Information: Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at the time of service unless other arrangements have been made and agreed upon.

Insurance: Depending on your policy and company, there is a possibility that massage and/or chiropractic care are covered benefits. We encourage you to contact a customer service representative with your insurance company. We also provide complimentary insurance verification. Please contact our business office at 541-687-7775 to verify insurance coverage 48-72 hours prior to receiving any scheduled services. Any services received without prior insurance authorization are unable to be billed to insurance companies.

Name of Insurance Company: _____

ID# / Policy #: _____

Authorization for care / Billing Insurance:

I hereby authorize the licensed massage therapist to work with my condition as he or she deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The licensed massage therapist will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I also understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

I acknowledge that I have read through and agree to the authorization for care and insurance policies described above.

Signature: _____ Date: _____

Cancellation Policy: 24 hour notice is required to avoid paying 50% of your massage fee. In the event of an unexpected illness, please call our office at 541-687-7775 by 8:00am on the morning of your massage in order to have the cancellation fee waived.

I have read and understand the Body of Light Massage Cancellation Policy.

Client Signature: _____ Date:_____

I have verbally reviewed our cancellation policies to the client and the client understands and agrees:

LMT Signature:_____ Date:_____

Left/Lost Personal Items: Body of Light Family Chiropractic assumes no responsibility for lost and left items.

Thank you for choosing Body of Light Family Chiropractic and Massage. We are looking forward to helping you heal and express your full health potential!

Massage Informed Consent

By signing below, you agree to the following for massage at Body of Light Family Chiropractic (BOLFC):

1) I give my permission to receive massage therapy.
2) I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.
3) I understand that the massage therapist does not diagnose illnesses or injuries or prescribe medications.
4) I understand the risks associated with massage therapy include, but are not limited to:
    - Superficial bruising
    - Short-term muscle soreness
    - Exacerbation of undiscovered injury

    I therefore release Body of Light Family Chiropractic and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.
5) I understand that it is my responsibility to inform the massage therapist of any discomfort I may feel during the massage session so she/he may adjust accordingly.
6) I understand that the nature of massage therapy/bodywork is for the purpose of health improvement and relaxation. I have stated all known medical conditions and will inform and update my therapist of any changes to my medical health as necessary. I understand that my session will be terminated due to any form of inappropriate behavior. We are committed to professionalism and expect the same from our clients. We will not tolerate **any** inappropriate acts.
7) **I have been given a chance to ask questions about the massage therapy session and my questions have been answered.**

_____ _____

Signature Date

<u>For minor children</u>:

I have read and understand the disclosures, policies and procedures of Body of Light Family Chiropractic and Massage and I would like to request a session for my child or dependent.

I authorize the therapists of Body of Light Family Chiropractic and Massage to provide massage to my child or dependent.

Name of child or dependent: _____

Child or dependent date of birth: _____

Parent or Guardian Name: _____

Parent or Guardian Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES
for BODY OF LIGHT FAMILY CHIROPRACTIC, PC dba
BODY OF LIGHT FAMILY CHIROPRACTIC

Revision Date: May 1, 2017

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.

If you have any questions about this notice, please contact the Privacy Officer of our office at (541) 687-7775.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practices and that of (1) any healthcare professional authorized to enter information into your medical record that we maintain at this office; and (2) all employees, staff, and other healthcare personnel.

YOUR MEDICAL INFORMATION. We create a record of the care and services you receive at this office. We need this record to provide you with quality service and to comply with certain legal requirements. This notice applies to all of the records about you maintained by this office. Other physicians or healthcare providers that you use may have different policies or notices regarding the use and disclosure of your medical information. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to (1) make sure that medical information that identifies you is kept private; (2) give you this notice of our legal duties and privacy practices with respect to medical information about you; and (3) follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. "Use" is what we do with your information in this office. "Disclose" means sharing your information with others outside this office. All of our permitted uses and disclosures of information fall within one of the categories.

- **For Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to chiropractor, office staff, or other personnel who are involved in your care.
- **For Payment**. We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party.
- **For Health Care Operations**. We may use and disclose medical information about you as reasonably necessary. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care.
- **To the Department of Health and Human Services (HHS)**. We must disclose your medical information when requested by HHS when it is undertaking a compliance investigation, review, or enforcement action.
- **To You**. We must disclose your medical information to you when you request it as described below. We may disclose your medical information to you in other situations.
- **Opportunity to Agree or Object**. We may disclose your medical information in front of others with your informal permission when you are present. If you are not present or otherwise unable to give permission, we may disclose your medical information to others if, in a healthcare provider's professional judgment, disclosure is determined to be in your best interest. This includes telling family or friends involved in your care about your current medical condition.
- **For Appointment Reminders**. We may use medical information about you to remind you about appointments using phone calls, emails, or text messages. This also allows us to leave appointment reminders and messages with limited information on your voicemail and answering machine.
- **Incidental Use**. Although we try to limit communications of your medical information to the minimum necessary, we can disclose information that is incidental to an otherwise permissible use.
- **Valid Authorization**. We may disclose your medical information pursuant to your written authorization. For authorization to be valid, you must sign a form containing certain statements.
- **Public Interest and Benefit Activities**. We may disclose medical information about you for 12 national priority purposes, including when required by law, such as statute or court order; for public health activities, such as providing immunization records to a school with a parent's permission; to government agencies regarding victims of abuse; to health oversight agencies to carry out legally authorized audits and investigations; pursuant to court orders and subpoenas that meet certain requirements; to law enforcement as described below; to a coroner or medical examiner; as necessary to facilitate organ or tissue donation and transplantation; for research purposes under certain circumstances; to prevent a serious threat to your health and safety or the health and safety of the public or another person; for certain essential government functions; and for workers' compensation or similar programs.
- **Law Enforcement**. We may disclose your health information if asked to do so by a law enforcement official (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) about a death we believe may be the result of criminal conduct; (3) about criminal conduct at the office; or (4) in emergency circumstances, in order to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- **Limited Data Set**. In certain situations we may disclose your medical information within a limited data set for research, healthcare operations, and public health purposes. A limited data set is medical information about you from which certain identifying information about you, your relatives, household members, and employers has been removed.

DISCLOSURES THAT REQUIRE AUTHORIZATION FROM YOU.

- **Psychotherapy Notes, Marketing, and Sales of Protected Health Information**. Most uses and disclosures of psychotherapy notes, protected health information for marketing purposes, and that constitute a sale of protected health information require authorization.
- **Other**. Other uses and disclosures not described in this notice will be made only with your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU. You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy**. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes prescriptions and billing records. To inspect and copy medical information that may be used to make decisions about you, you may be required to submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We will select a licensed healthcare professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for this office.
  To request an amendment, complete and submit an AMENDMENT REQUEST form to the Privacy Officer.
  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the medical information kept by or for the office; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.
- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you.
  To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.
  We are not required to agree to your request unless (1) the disclosure is for the purposes of carrying out payment or healthcare operations, and (2) the protected health information pertains to an item or service which you, or another person other than your health insurance, have paid for in full. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
  To request restrictions, you may complete and submit the REQUEST FOR LIMITATION AND RESTRICTION OF PROTECTED HEALTH INFORMATION to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
  To request confidential communications, you may complete and submit the PATIENT'S REQUEST TO LIMIT CONFIDENTIAL COMMUNICATIONS to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Privacy Officer.
- **Right to Receive Notice of Breach**. You will receive notification of breaches of your unsecured protected health information unless we determine there is a low probability your PHI was compromised.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office. The summary will contain, in the top right-hand corner the effective date. You are entitled to a copy of the current notice in effect.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact the Privacy Officer. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

BODY OF LIGHT FAMILY CHIROPRACTIC, PC

RECEIPT OF NOTICE of PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM

I, _____, have received a copy of Body of Light Family Chiropractic, PC's Notice of Privacy Practices.

_____ _____
(Signature of patient or legal guardian) (Printed patient or guardian name)

Date: _____, 20___

FOR INTERNAL PURPOSES ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign
___ Communication barriers prohibited obtaining the acknowledgement
___ An emergency situation prevents us from obtaining acknowledgment
___ Other (please specify): _____
_____
_____