Melissa Briscoe Lamarche
DC, BA, CCSP, ATC, CSCS
595 Roswell St. Suite G
Marietta GA, 30060

PERSONAL INFORMATION

Date: ________________

Name: ____ Birthday: ______________________ Age: ________ Sex: ☐Male ☐Female

Address: ____

Phone: ____ E-mail: ____

Occupation: ____ Employer: ____

If patient is a minor, parent / guardian name(s): ____

Emergency Contact & Phone Number: ____

Height: ________ Weight: ________ Referred By: ____

Marital Status:☐Married ☐Domestic Partner ☐Single ☐Widowed ☐Divorced Name of Spouse/Partner:__________________________

Do you have children?☐Yes ☐No Number of Children: ____ Name(s): ____

Do they live at home? ☐Yes ☐No How are your family relationships? (i.e. good, stressful, none) ________________________________

Average hours of sleep/rest per day? _______What is your quality of sleep? ☐Good ☐Fair ☐Poor

Do you exercise? ☐Yes ☐No What do you do for exercise and how often? ____

What are your play and relaxation activities? ____

Have you had previous Chiropractic Care? ☐Yes ☐No Who? ____

Date of last adjustment: _____________________ How long were you under care? ___________________________

What is your level of commitment to yourself, your life and well-being? ☐High ☐Medium ☐Low

What things have you done to improve your health and well-being? (yoga, trainer, herbs, massage, etc)?___________________________

____

What do you feel is your primary stress? ____

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CONFIDENTIAL HEALTH HISTORY

Please list the main health complaints you have in order of their importance to you:

What is the main reason for your visit today? ______________________________

When did it start? ____________ How often does it happen? ____________

Is it getting ☐better ☐worse or ☐staying the same? What have you tried to do for it? ____________

What makes it better? ____________ What makes it worse? ____________

Dr. Notes:

Do you have another health concern? ______________________________

When did it begin? ____________ How often are you aware of it? ____________

Is it getting ☐better ☐worse or ☐staying the same? What treatments have you tried? ____________

What makes it better? ____________ What makes it worse? ____________

Dr. Notes:

Any other health challenges you would like to discuss today? ______________________________

Began how long ago? ____________ How often does this happen? ____________

Is it getting ☐better ☐worse or ☐staying the same? What have you tried to do for it? ____________

What makes it better? ____________ What makes it worse? ____________

Please list any previous diagnosis, major illnesses, injuries or surgeries:

____

____

Is there anything about your Spine or Nervous System that I should know about?

____

____

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Please check any of the following health conditions you experience. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

Related to the **Cervical Spine** (neck):

☐Dizziness ☐Sinus / Allergies ☐Neck Pain ☐Headaches/ Migraines ☐Sleeping Difficulty
☐Fatigue ☐Ringing in the Ears ☐Depression ☐Visual Disturbances ☐Frequent Sighing or Hiccups
☐Irritability ☐Weight Difficulty ☐Dry Mouth ☐Thyroid Problems ☐Difficulty Concentrating

Related to the **Thoracic Spine** (mid-back):

☐Heart Problems ☐Shortness of Breath ☐Asthma ☐Reflux or Indigestion ☐Gall Bladder Problems
☐Mid-Back Pain ☐Chest Pain ☐Poor Posture ☐High Blood Pressure ☐Bloating

Related to the **Lumbar Spine** (low back):

☐Low Back Pain ☐Colitis ☐Digestive Disturbances ☐Problems with Urination
☐Irritable Bowel ☐Constipation ☐Freq. Urinary Tract Infections ☐Pain that goes down my leg(s) Right / Left / Both

For Women: ☐Irregular Cycles ☐PMS ☐Difficulty Getting Pregnant ☐Heavy Flow ☐Scant Flow
Are you currently pregnant? ☐Yes ☐No If yes, how far along? ____________ Due date: ______________
Are you currently nursing? ☐Yes ☐No Are you taking birth control? ☐Yes ☐No

For Men: ☐Erectile Dysfunction ☐Prostate Problems

Have you or anyone in your family been diagnosed with the following?
☐Heart Disease ☐Stroke ☐Diabetes ☐Cancer ☐High Blood Pressure

Health Habits

Do you smoke? ☐Yes ☐No
Do you drink alcohol? ☐Yes ☐No
Do you drink coffee? ☐Yes ☐No
Do you take vitamins? ☐Yes ☐No
Please list: _______________________
____
____

Medications I Now Take

☐ Nerve Pills ☐ Stimulants ☐ Insulin ☐ ADHD
☐ Pain Killers ☐ Blood Thinner ☐Cholesterol Medication
☐Muscle Relaxer ☐ Tranquilizer ☐Blood Pressure Medication
☐Anti-depressant or Anti-anxiety ☐ OTC: ___________________
☐Other: ____
____

Goals for My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that I may be guided by your wishes whenever possible.

___ **Relief Care**: Symptomatic relief of pain or problem.
___ **Restorative Care**: Correcting the cause of the problem as well as symptoms.
___ **Comprehensive Care**: Bring whatever is malfunctioning in the body to the highest state of health possible.

Please tell me about your health and life goals: ____
____

On a scale of 10, what is your current level of desire to correct your current health challenge? 1 2 3 4 5 6 7 8 9 10

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Authorization for Care

Chiropractic has one primary goal: to optimize the health of the nervous system through proper alignment of the spine. The doctor does not offer to diagnose or treat any condition other than those covered under their scope of practice. However, if the doctor should encounter a non-chiropractic or unusual finding, the doctor will advise you of the findings and refer you to the appropriate provider. I hereby consent to the performance of chiropractic adjustments and recommended procedures, including various modes of physical therapy and suggested nutritional supplementation by Melissa Briscoe Lamarche DC. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, rib fractures and stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I understand that I am responsible for all fees incurred in this office and that all original files belong to the office

Patient Signature: ___________________________________ Date: ____________________

Minor: ☐ I ____ (print name) authorize treatment of my minor child.

Parent Signature: ___________________________________ Date: ____________________

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

If you have any questions about the above notice, please contact Dr. Melissa at 404-825-1629.

Our Obligations. We are required by law to:
- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information Described as follows are the ways we may use and disclose health information that identifies you (“Health Information”). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practices privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, Health Information, Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about lab results, treatment alternatives or health related benefits and services that may be of interest to you. We may use your email address for such purposes.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations. As required by law. We will disclose Health Information when required to do so by international, federal, state, or local law:

To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers Compensation. We may release Health Information for workers compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the persons agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights. You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have 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 our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. We are not required to agree with your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must 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. You may obtain a copy of this notice by contacting our office.

Changes to This Notice. We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints. If you believe your privacy has 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 our office, contact our Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Patient Name:____ Date of Birth:____________________

Patient Signature: ____ Date: ________________

Parent /Guardian Name: ______________________________ Signature: _____________________________ Date: ___________

***If there is anyone whom we may share your health information, (spouse, family member, etc) please list below:**

Name: ____ Contact information: ____

Name: ____ Contact information: ____

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HIPAA Email and Text Messaging Consent

- HIPAA stands for the *Health Insurance Portability and Accountability Act*

- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information

- Information stored on our computers is encrypted

- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email

- **When we send you an email or text message, or you send us an email or text message, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet and wireless servers.**

In addition, once an email or text message is received by you, someone may be able to access your email account or phone and read it.

- Email and text are very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA

- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website - http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

- The guidelines state that if a patient has been made aware of the risks of unencrypted email and text messaging, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email or text message.

☐ OPTION 1 – **ALLOW** UNENCRYPTED EMAIL and Text Messaging
I understand the risks of unencrypted email and do hereby give permission to the Austin Med Clinic to send me personal health information via unencrypted email

Signature: ____ Date:______________________

Printed Name: ____ (parent or guardian if patient is a minor)

***Please list telephone/ text number: _________________________________**

***Please print email address: ____**

☐ OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL or Text Messaging
I do not wish to receive personal health information via email

Signature: ____ Date: ____________________

Printed Name: ____ (parent or guardian if patient is a minor)