WELCOME TO LIGHTSOURCE CHIROPRACTIC!

We are thrilled that you have chosen us for your family wellness needs. Please be thorough as you fill out these sheets, and let us know if you have any questions. Remember, the neater you write, the less questions we will have!

Team LightSource
908.238.1081

HIPPA

This Notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information has always been important to us and we are committed to protecting it. New federal laws, however, require that we provide each of our patients with an official notice of our privacy practices. This notice will inform you of ways we use and share your information and it will describe your rights and our duties regarding the use and disclosure of health information.

Law requires us to:

- Keep your health information private
- Give you this Notice of Privacy Practices
- Abide by the terms of the Notice of Privacy Practices currently in effect

We have the right to:

- Change our privacy practices and the terms of this notice at any time, provided that law permits the changes. If we make changes, we will update this notice and make the new notice available upon request.

Listed here are some of the ways we may use or disclose your information without your specific consent or authorization. Not all possible uses or disclosures are listed.

For Treatment: We may use health information about you to provide you with treatment or services. We may disclose health information about you to doctors, nurses, technicians, or other people who are taking care of you. We may also share health information about you with your other health care providers to assist them in treating you.

For Payment: We may use and disclose your health information for payment purposes.

For Health Care Operations: We may use and disclose your health information for our health care operations. For example, we may use health information about you to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Possible Uses and Disclosures:

- In response to a legal proceeding
- For other healthcare provider's treatment activities
- For other covered entities and provider's payment activities
- In case of threat to public health or safety
- To notify a family member in certain emergency situations
- To workers' compensation or similar programs for processing of claims
- In domestic violence or neglect situations
- Other uses and disclosures not in this notice will be made only as allowed or required by law or with your written authorization.

The health and billing records we create are the property of this healthcare facility. The health information in it, however, generally belongs to you.

You have the right to do the following:

- Request and receive from us a copy of the most current Notice of Privacy Practices.
- Look at or receive copies of your health information. You may make this request in writing and we have a form available for that purpose. We reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request.
- Ask us to restrict certain uses and disclosures. You must submit this request in writing. We are not required to grant the request but will comply with any request granted.

- Have us review a denial of access to your health information -- except in certain circumstances.

- Ask us to change your health care information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of records.
- Request a list of disclosures of your health information. The list will not include disclosures to third party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by other means or at another location. Please sign, date and give us your request in writing. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.
- Cancel a prior authorization to use or disclose health information by giving us a written revocation. Your revocation does not affect any information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

Open or Group Adjusting Authorization Request: You will receive chiropractic adjustments in a room where other clients are also receiving chiropractic care. In the course of your care in such an environment, routine details of your condition and care may be disclosed to other clients or staff in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addressed and considered as confidential by other clients. However, we can offer you the opportunity to discuss your health care in a more private setting at your request.

We are requesting your authorization in this regard to assure that you are fully informed and in agreement with all of the methods and circumstances in which we deliver chiropractic care. Your care will not be conditioned on your agreement to this authorization. You have the right not to sign this authorization and you also have the right to revoke this authorization at a later date if that is your wish. If you wish to revoke this authorization at some time in the future, please advise us accordingly in writing.

Photographs and Testimonials: From time to time we have our practice members write out or verbally share there experience with care, to share with other practice members. We also take photos of all of the kids in the practice in celebration of health and wellness, and display them on the wall. We are requesting your authorization for this matter.

We may also have sign up sheets posted at the front desk for email lists or health class sign up sheets (and the like).

If you have questions or wish to report a problem, you may contact the Privacy Officer at 908.399.3499
If you believe you privacy rights have been violated, you may discuss your concerns with any staff member. You may also file a complaint with the Privacy Officer at our practice, or with the U.S. Secretary of Health and Human Services. All complaints must be in writing. You will not be penalized or discriminated against for filing a complaint.

To contact us: LIGHTSOURCE CHIROPRACTIC
6 EAST MAIN STREET
CLINTON, NJ 08809

Consent of Privacy Statement

This page is for our office

This notice is effective as of _____. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received copy of LightSource Chiropractic's Notice of Privacy Practices.

_____

Practice Member Name Printed Date

_____

Practice Member or Guardian Signature Date

_____

Printed Name of Guardian Date

_____

Description of Guardian Date

INSURANCE INFORMATION:

We will check your insurance for you! We do NOT work with HMO's or medicare. Please give us the following information:

Name of Primary Insured_____
DOB of Primary Insured_____

Patient Name_____
Patient DOB_____

Insurance Company_____
Insurance Phone Number_____
Policy Number_____
Group Number_____

Insurance address for billing (on back of card)
_____
_____

Best number to reach you at: _____

LIGHTSOURCE CHIROPRACTIC
ADULT HEALTH HISTORY

Please be as detailed as possible. The more information we have, the more we know how to help you!

Name_____

PHONE NUMBER _____ EMAIL _____

ADDRESS: _____

_____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

OCCUPATION _____DATE OF BIRTH _____

ARE YOU INTERESTED IN HAVING ANY FAMILY MEMBERS CHECKED BY DR. JODI AT THIS TIME? IF SO, PLEASE LIST THEIR NAME AND AGE:

_____

For Parents:

NAMES AND AGES OF KIDS_____

YOUR SPOUSE'S NAME _____ OCCUPATION_____

Birthing mamas & new mamas....

ARE YOU CURRENTLY PREGNANT OR TRYING TO GET PREGNANT?
_____No, not pregnant, not trying
_____We are trying, have been for a while
_____We just started trying
_____Not sure

ARE YOU NURSING?
_____Yes
_____No
_____I just stopped
_____I was not able to produce milk

IF YOU ARE A MOM, PLEASE TELL US ABOUT YOUR BIRTH HISTORY. INCLUDE ANY INTERVENTION, DRUGS, EPIDURALS, SURGERY, ETC.

HAVE YOU EVER HAD A MISCARRIAGE? IF SO, DATES AND LENGTH OF PREGNANCY?
IF YOU ARE CURRENTLY UNDER PRENATAL CARE, PLEASE LIST YOUR HEALTH CARE PROVIDERS. INCLUDE DOULAS, OBGYN, MIDWIVES, ETC:

HOW WOULD YOU DECRIBE YOUR CURRENT STATE OF HEALTH:

WHY ARE YOU SEEKING TREATMENT IN OUR OFFICE AT THIS TIME?

WHAT DO YOU HOPE TO GET OUT OF YOUR EXPERIENCE AT LIGHTSOURCE CHIROPRACTIC?

ON A SCALE OF 1-10, 10 BEING YOUR BEST POSSIBLE HEALTH AND 1 BEING VERY SICK, WHERE DO YOU FEEL YOU ARE TODAY? _____

WHERE DO YOU WANT TO BE? _____

WHAT DO YOU NEED TO REACH YOUR GOAL? COMMENTS / OTHER:
_____Chiropractic care
_____Better diet
_____More movement
_____Less emotional stress
_____Better spiritual connection
_____Less physical stress
_____Time management

HOW LONG DO YOU FEEL IT WILL TAKE TO REACH YOUR GOAL?

_____3 Months
_____6 Months
_____12 Months
_____OTHER_____

DO YOU HAVE ANY FEARS / CONCERNS ABOUT SEEING DR. JODI?

WE HAVE SOME WONDERFUL ANCILLARY SERVICES AT LIGHTSOURCE! PLEASE CHOOSE ANY THAT YOU ARE INTERESTED IN AND WE WILL HAVE THE RIGHT PERSON CONTACT YOU WITH INFORMATION!

_____Young Living Essential Oils
_____LightSource Massage
_____Mastery Coaching with Dr. Jodi
_____None at this time

Your health history:

PLEASE LIST ANY SURGERIES YOU HAVE HAD, AS A CHILD AND AS AN ADULT. INCLUDE DATE AND REASON:

PLEASE LIST ANY SERIOUS ILLNESS OR DISEASE YOU HAVE HAD OR CURRENTLY HAVE, AS A CHILD AND AS AN ADULT. INCLUDE DATE AND TREATMENT:

PLEASE LIST ANY BROKEN BONES, TORN LIGAMENTS, SPRAINS OR STRAINS. INCLUDE LOCATION, DATE AND HOW IT HAPPENED.

HOW WOULD YOU DESCRIBE YOUR DIET? WHAT DID YOU HAVE FOR DINNER LAST NIGHT? BE DETAILED HERE.

WHEN WAS YOUR LAST PHYSICAL AND WHAT DID YOU LEARN ABOUT YOURSELF?

HAVE YOU EVER BEEN TO A CHIROPRACTOR? IF YOU HAVE, WHEN WAS YOUR LAST ADJUSTMENT AND WITH WHOM? WHAT DID YOU LOVE MOST ABOUT THEIR CARE? LEAST? IF YOU HAVE NEVER SEEN A CHIROPRACTOR, WHY NOT?

WHAT IS YOUR CURRENT EXCERSIZE REGIME? ARE YOU HAPPY WITH IT?

WHY DOES NOW FEEL LIKE A GOOD TIME TO RECEIVE CARE WITH DR. JODI?

PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS YOU CURRENTLY TAKE, AMOUNT AND WHAT YOU TAKE THEM FOR:

ARE THERE FOODS THAT YOU ABSOLUTELY STAY AWAY FROM? IF SO, PLEASE LIST FOODS AND REASONS:

PLEASE LIST ALL ALLERGIES, COMMON AILMENTS, ACHES AND PAINS THAT YOU EXPERIENCE:

WHO ARE YOUR CURRENT HEALTH CARE PROVIDERS? WHAT DO YOU SEE THEM FOR?

WHAT ARE THE TOP THREE ATTRIBUTES YOU LOOK FOR IN A FAMILY PRACTICE?

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT?