Lim Chiropractic & Rehab Center

Kwang-Ho Lim D.C.

LIM CHIROPRACTIC & REHAB CENTER

PATIENT INTAKE FORM

1836 Westlake Ave N | Tel: (206)492-7131 | Fax: (206)717-2908 | limchirorehab.com

PATIENT INFORMATION

Last Name:	First Name:	Middle:
Birth Date:	Phone:	Email:
Adress:		
City:	State:	ZIP Code:
Occupation:	Employer:	

How did you hear about us? ☐ Doctor ☐ Hospital ☐ Close to home/work
☐ Family ☐ Friend ☐ Insurance Network ☐ Others:

If someone referred you, who?

IN CASE OF EMERGENCY

Name:	Relationship:	Phone:
Name: (Optional)	Relationship:	Phone:

INSURANCE INFORMATION

(Skip this part if you do not have the insurance.)

Insurance Company:	Group Number:
Member ID Number: (Please include the PREFIX if given)	

REASON FOR VISIT

☐ General ☐ Car Accident ☐ Work Injury ☐ Other Accident

PREVIOUS ACCIDENTS / INJURIES

Past Auto Accidents? ☐ Yes ☐ No	How recent?	Treatment? ☐ Yes ☐ No	
Past Work Injury? ☐ Yes ☐ No	How recent?	Treatment? ☐ Yes ☐ No	
Other Injuries? ☐ Yes ☐ No	How recent?	Treatment? ☐ Yes ☐ No	

FAMILY HISTORY

NAME	PRESENT SYMPTOMS	PREVIOUS ILLNESS

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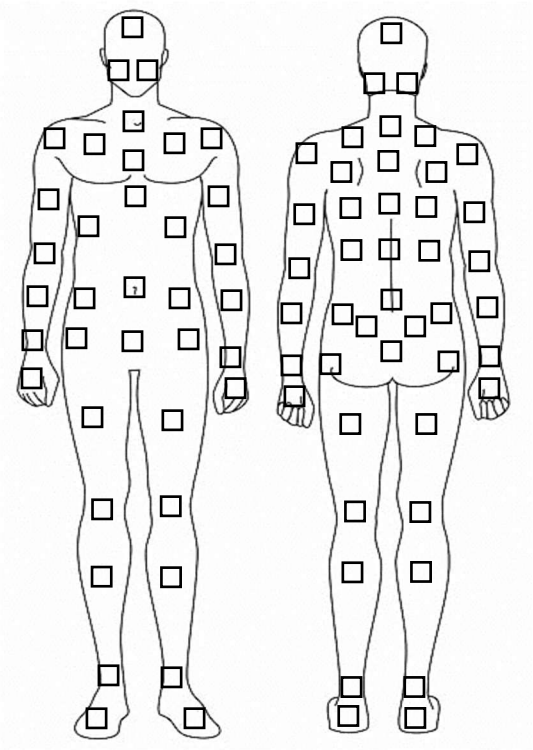

PRESENT COMPLAINTS

(Please use the chart on the left to show the areas of pain.)

1.	
How long?	
2.	
How long?	
3.	
How long?	
Have you received other treatment for these conditions?	☐ Yes ☐ No
If yes, who and where?	

GENERAL SYMPTOMS

(Check any you currently have or have had in the past year.)

Numbness of Pain in:	☐ Arms	☐ Hands	☐ Legs	☐ Feet
Headache:	☐ Sinus	☐ Tension	☐ Migraine	
☐ Back Pain	☐ Neck Pain	☐ Hip Pain		
☐ Pain Between Shoulders	☐ Neck Stiffness	☐ Muscle Spasms		
☐ Sciatica	☐ Dizziness	☐ Loss of Sleep		
☐ Allergies	☐ Asthma	☐ Difficulty Breathing		
☐ Digestive Problems	☐ Hearing Problems	☐ Visual Problems		
☐ Menstrual Problems	☐ Ear Infections			
☐ Others:				
Date of last menstrual cycle:	Are you pregnant? ☐ Yes ☐ No			

I hereby state that the above information is true to the best of my knowledge. I authorize *Lim Chiropractic and Rehab Center* to examine, take x-rays, treat me, and do whatever they deem necessary in accordance with the state statues for the care and management of my condition(s). I understand and agree that the health and accident insurance policies are an arrangement between the insurance carrier and me. I understand that I am financially responsible for any balance, and that any amount authorized to be paid directly to *Lim Chiropractic and Rehab Center* will be credited to my account on receipt. I also authorize *Lim Chiropractic and Rehab Center* or the insurance company to release any information required to process my claims. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

_____ _____

Patient / Guardian signature Date

Lim Chiropractic & Rehab Center

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CLIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement. In refusing we *may not be allowed* to process your insurance claims.

Date: _____ Client DOB: _____

The undersigned acknowledges a copy of the currently effective Notice of Privacy Practices for *Lim Chiropractic & Rehab Center* was provided. A copy of our Privacy Practices can also be found on our website at www.limchirorehab.com

I consent to Lim Chiropractic & Rehab Center Staff leaving detailed voice messages.

I consent to Lim Chiropractic & Rehab Center Staff using my cell phone number for care and billing related text messages.

In signing this HIPAA Client Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. We, under the current HIPAA Omnibus Rule, provide you with this information with your knowledge and consent.

_____ _____

Please *print* client name Client Signature (13 or older)

_____ _____

Parent or Legal Representative Signature Relationship to client

****

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the client's (or representative's) signature on this Acknowledgement but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the client
- ☐ The client refused to sign
- ☐ The client was unable to sign because _____
- ☐ Other (please describe) _____

Signature of Privacy Officer

HIPAA Notice of Privacy Practices April 15, 2024

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.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information.
- Let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy officer.

For 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.

For 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 the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

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

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

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 clients who received one treatment to those who received 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 clients who may be included in their research project or for other similar purposes, if they do not remove or take a copy of any Health Information.

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 or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or 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 our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified 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 armed forces, we may 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 disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a client has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized 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.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative 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 a crime even if, under certain very limited circumstances, we are unable to obtain the person's 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, the location of the crime or victims, or the identity, description or location of the person who committed the crime. Coroners, Medical Examiners and 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 also may 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 for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose 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 under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be 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) the safety and security of the correctional institution.

Please note we do not create or manage any hospital directories at any of our locations. We also do not create or maintain any psychotherapy notes at this practice.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information
3. Most sharing of psychotherapy notes

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

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

Get an electronic or paper copy of your medical record: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. To inspect and copy this Health Information, you must make your request, in writing, to Lim Chiropractic & Rehab Center.

Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days. To request an amendment, you must make your request, in writing, to Lim Chiropractic & Rehab Center.

Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

We will say "yes" to all reasonable requests. To request confidential communications, you must make your request, in writing, to Lim Chiropractic & Rehab Center.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

To request a restriction, you must make your request, in writing, to Lim Chiropractic & Rehab Center.

Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. To request an accounting of disclosures, you must make your request, in writing, to Lim Chiropractic & Rehab Center.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights have been violated: You can complain if you feel we have violated your rights by contacting us using the information at the bottom of this notice.

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 copy of our current notice at our office. The notice will contain the effective date on the first page.

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 our office, contact Kwang-Ho Lim (drl@limchirorehab.com). All complaints must be made in writing. **You will not be penalized for filing a complaint.**