Restoration BodyWorX

Confidential Patient Health Information

Personal Information:

First Middle Last Sex
Name: ____ ☐ M ☐ F

E-mail address:____

Address: _________________________City/ST________________________ZIP:________

Home Phone: ( ) ____-______ Work Phone: ( ) _____-______X____ Cell Phone ( ) ______-________

SS#: ______/_____/_______Birth date: ___ /____/____ Marital Status: ____(**M**arried, **S**ingle, **O**ther)

Employer: _________________________Occupation: ___________________

Nearest Relative: _______________________ Relationship: ________________ Phone: ( ) _____-________

HOW WERE YOU REFERRED?____

Reason for your Visit:

Have you been to this clinic before? ☐ Yes ☐ No

Purpose of this appointment____

Reason for your visit is a result of (please circle): Wellness, Work Injury, Auto Accident, Trauma, Chronic Problem, Other

Please describe the pain and its location: ____
Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

Date of accident/injury, or when condition began: ___________/_________/___________

Is condition getting worse? ☐ Yes ☐ No ☐ Staying the Same ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other

Have you been treated by another doctor for this condition? ☐ Yes ☐ No

If yes, please name doctor/health care facility: ____

Insurance Information:

Company Name: ________________________________ Phone: ( ) _________-_____________

Address: ________________________City/ST: ___________________________ZIP:________

Name of Insured: _____________________________________ SS#: _________/______/_________

Insured ID (if different than SS#): _________________________ Insured's Birth date: ____/____/____

Policy/Group #: _________________________________ Plan Name: ________________________

Relationship to you: __________ Insured's Employer: ____________________ Effective Date: ____/____/_____

17680 Butterfield Blvd, Ste # 200 – Morgan Hill, CA 95037 (408) 422-3774 Fax (408) 762-6101

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You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blueprints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in massage therapy care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

3. Current Health Habits

Did or do you...

Smoke?	Y	N	________________
Drink	Y	N	________________
Diet (do you eat healthy foods?)	Y	N	________________
Have you been in accidents?	Y	N	________________
Drugs? (Prescriptive or Non-Prescriptive)	Y	N	________________
Have Teeth Problems?	Y	N	________________
Have Eye Problems?	Y	N	________________
Have Hearing Problems?	Y	N	________________
Exercise regularly?	Y	N	________________
Have sleeping problems? (Nightmares)?	Y	N	________________
Have occupational stress?	Y	N	________________
Have physical stress?	Y	N	________________
Have mental stress?	Y	N	________________
Have hobbies/sports injuries?	Y	N	________________

Sleeping posture – side–stomach–back ________________

Other symptoms:

- ❒ Headaches
- ❒ Neck Pain
- ❒ Sleeping Problems
- ❒ Back Pain
- ❒ Nervousness
- ❒ Tension
- ❒ Irritability
- ❒ Chest Pains
- ❒ Dizziness
- ❒ Face Flushed
- ❒ Neck Stiff
- ❒ Pins & Needles in Legs
- ❒ Pins & Needles in Arms
- ❒ Numbness in Fingers
- ❒ Numbness in Toes
- ❒ Shortness of Breath
- ❒ Fatigue
- ❒ Depression
- ❒ Light Bothers Eyes
- ❒ Loss of Memory
- ❒ Ears Ring
- ❒ Fever
- ❒ Fainting
- ❒ Cold Sweats
- ❒ Loss of Smell
- ❒ Loss of Taste
- ❒ Diarrhea
- ❒ Feet Cold
- ❒ Hands Cold
- ❒ Stomach Upset
- ❒ Constipation
- ❒ Loss of Balance
- ❒ Buzzing in Ear

Have you been under drug and medical care? ____

What medications are you taking? ____

How Long? ________________ Have you had surgery for this condition? _____ What and When?

____

What side effects have you experienced from the drugs and surgery? ______________________

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other ______________
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

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Upon the completion of your first visit, you will receive a Massage Therapy Report to discuss the different types of Active Life Plans that are available to you. Massage Therapy Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the

Massage Therapy Active Life Plans prior to your Massage Therapy Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my Massage care, I would like to

Please check all that apply

- ❒ Feel better quickly
- ❒ Have a healthier Body
- ❒ Better Flexibility
- ❒ Have a healthier body by keeping my nerve system healthy
- ❒ Live a healthier lifestyle

__________________________________ Signature

_____________________ Date

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for care, payment and healthcare operations. For example:

Health Care

We may use or disclose your health information to a physician or other healthcare provider providing care to you.

Payment

We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations

We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization

In addition to our use of your health information for your care, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends

We must disclose your health information to you, as described in the Patient Rights Section of this Notice. We may disclose health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care

We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up x-rays or other similar forms of health information.

Marketing Health-Related Services

We will not use your health information for marketing communications without your written authorization.

Required by Law

We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect

We may disclose your health information to appropriate authorities if we can reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody or protected health information of inmate or patient under certain circumstances.

Appointment Reminders

We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Rowdy D. Hall, CMT
Dr. Shawn Silva D.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give this Notice about our privacy practices, and our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 4/02/07. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed in this Notice.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed in this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address in this Notice. If you request copies, we will charge you $0.20 cents for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed in this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 7 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means, or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the Office for Civil Rights. We will provide you with the address to file your complaint with the Office for Civil Rights upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the Privacy Officer or with the Office for Civil Rights.

Privacy Officer Dr. Shawn Silva, D.C. (408) 776-8608 Fax: (408) 762-2012 Address:18525 Sutter Blvd. Suite 170
Morgan Hill, CA 95037

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

This form does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of August 14, 2002. Subsequent law changes may require Form revision.

Patient Signature___________________________ Date: _______________
Witness Signature___________________________ Date: _______________