Gray Chiropractic Center

Chris J. Dombrowski, D.C. Fran Dombrowski, D.C.
2 McConkey Rd., Suite 3, Gray, ME 04039
Ph: 207-657-5200 Fax: 207-657-5202

Payment Information

Name (first, middle, last): _____

Address: _____

City: _____ **State:**_____**Zip:**_____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email address:** _____

Last four digits of your social security number #: _____

If we need to contact you during the day, which number is best? ○Home ○Cell ○Work

Date of Birth: _____ **Occupation:** _____

Emergency contact: _____ **Phone:** _____**Relationship**_____

Insurance Carrier: _____**Policy Number:** _____

Insured's Name: _____

Who carries this policy? ○Self ○Spouse ○Parent
(If spouse or parent, please provide their information below)

Policy Holder's Name _____**Date of Birth:** _____

Policy Holder's SS#: _____**Policy Holder's Phone:** _____

Policy Holder's Place of Employment: _____

I authorize my insurance company to pay this chiropractor/health center all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the chiropractor/health center to release all information necessary to secure payment of benefits.

I understand I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Health History

Please fill in the blanks or place an "X" on all circles that apply.

Name: _____ Birthdate: _____Age: ___

Please describe the reason for your visit today. _____

_____

Is this problem the result of: ○ A work injury ○ An auto accident

Where would you rate your pain at it's worst? 0 1 2 3 4 5 6 7 8 9 10
None Little Medium Severe

When did you first notice your current problem?_____

How frequent is this condition? ○ Daily ○ Weekly ○ Night Only

Is your condition: ○ Constant ○ Frequent ○ Intermittent ○ Occasional

Does the pain shoot or travel to any other area? _____

What makes it worse? ○ Sitting ○ Standing ○ Walking ○ Bending

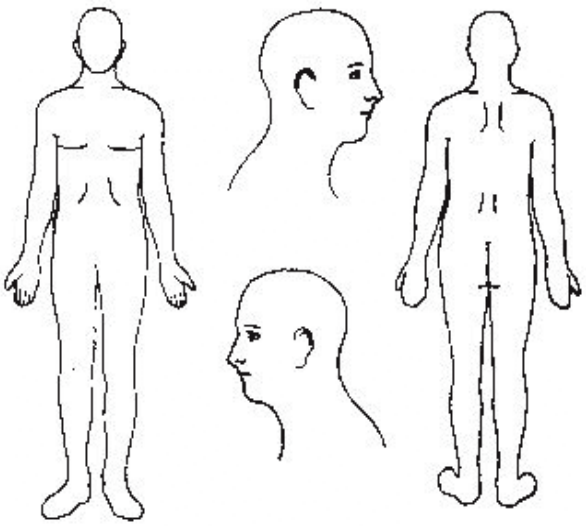
○ Lifting ○ Sleeping/Laying ○ Sneezing/Coughing ○ Reaching

○ Twisting ○ Looking Up/Down ○ Driving ○ Movement ○ Stairs

Other: _____

Does anything make it better? _____

Please mark the location of your problem and check all words that apply:



- ○ Dull Ache
- ○ Tingling
- ○ Sharp
- ○ Stabbing Pain
- ○ Throbbing
- ○ Cramping
- ○ Burning
- ○ Numbness
- ○ Deep
- ○ Stiffness

Anything else we should know about your current condition?

_____

_____

Chiropractor's Notes

_____
Initials

Gray Chiropractic Center
2 McConkey Rd., Ste. 3
Gray, ME 04039
207-657-5200

Have you seen a chiropractor before? ○ Yes ○ No

Have you seen anyone else for this condition? ○ Yes ○ No

Have you been treated for any condition by any physician in the last year?

○ Yes ○ No Describe:_____

Review of systems:

Do you experience problems in the following systems?

	Yes	No
Musculoskeletal (bones, joints, posture, TMJ, etc.)	○	○
Neurological (dizziness, tingling, numbness)	○	○
Cardiovascular (blood pressure, circulation)	○	○
Respiratory (lungs, allergies, breathing)	○	○
Digestive (stomach, digestion, colon, bloating, gas)	○	○
Sensory (eyes, ears, smell, taste)	○	○
Integumentary (skin, hair, nails, eczema, psoriasis)	○	○
Endocrine (thyroid, low energy, poor sleep)	○	○
Genitourinary (kidney, bladder, prostate)	○	○
Constitution (appetite, fatigue, weight change)	○	○

Primary Physician's Name: _____Phone: _____

Prescription or over-the-counter drugs you are taking: ○I'm not taking any

_____

_____

_____

Do you take vitamins/herbs/homeopathy? ○ Yes ○ No

Past Personal History:

Have you ever had any of the following problems? ○ Arthritis ○ Cancer
○ Diabetes ○ Frequent Constipation ○ Frequent Headaches ○ Stroke
○ Heart Disease ○ High Blood Pressure ○ Osteopenia/Osteoporosis

Have you had any operations, which may or may not have included hospitalization?
○ Yes ○ No List:_____

Have you had any accidents or injuries, such as:
○ Broken bones ○ Been knocked unconscious ○ Been in any auto accident
○ Concussion ○ Other: _____

Name

DOB

DC Initials

Gray Chiropractic Center
2 McConkey Rd., Ste. 3
Gray, ME 04039
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Name/DOB

DC Initials

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Family History:

Are there problems that run in your family?

○ Cancer ○ Diabetes ○ High Blood Pressure Other: _____

Social History:

Alcohol use ○ None ○ Occasional ○ Weekly/Drinks per week _____

Tobacco use ○ Yes ○ No

Exercise ○ Regularly ○ Sometimes ○ Never

Stress Level ○ Low ○ Moderate ○ High

Sleep ○ Back ○ Side ○ Stomach Average hours per night? _____

Work Activity: ○ Sitting ○ Standing ○ Light Labor ○ Heavy Labor

Activities of Daily Living:

How does this condition currently interfere with your life and ability to function? Please place and "X" over each bubble that applies.

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Personal Care	○	○	○	○	Driving/Traveling	○	○	○	○
Lifting	○	○	○	○	Duties at work	○	○	○	○
Walking	○	○	○	○	Concentration	○	○	○	○
Sitting	○	○	○	○	Recreation	○	○	○	○
Rising from Chair	○	○	○	○	Exercising	○	○	○	○
Standing	○	○	○	○	Caring for family	○	○	○	○
Sleeping	○	○	○	○	Yard/Housework	○	○	○	○
Using a computer	○	○	○	○	Reading	○	○	○	○

I realize an X-ray examination may be hazardous to an unborn child. I certify to the best of my knowledge that:

○ I am not pregnant.

○ I am pregnant.

* *

Acknowledgement

To the best of my ability the information I have supplied is complete and truthful. I have not mis-represented the presence, severity or cause of my health concern.

Signature: _____ Date: _____

Gray Chiropractic Center 2 McConkey Rd., Suite 3, Gray, ME 04039

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process if often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns/scarring from cold packs, skin irritation from topical analgesics, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustments do not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to the medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major gastrointestinal events of the entire (upper and lower) GI tract was 1,219 events/per million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient name(Print):_____Signature:_____Date:_____

Parent/Guardian Name(Print):_____Signature:_____Date:_____

Witness Name:_____Signature:_____Date:_____

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207-657-5200

Your Financial Responsibility

By requesting chiropractic services from GRAY CHIROPRACTIC CENTER on behalf of yourself and/or your dependents, you become fully financially responsible for any and all charges incurred in the course of your care. Please carefully read each point. If you are using insurance sign the Assignment of Benefits at the end of this document.

Insurance

It is the responsibility of each patient to understand the terms, benefits and limitations of their insurance policy.

We can give you a list of helpful questions to ask your insurance company about your policy upon request. Chiropractic benefits often differ from medical benefits so information on your card may not be accurate.

Please be ready to pay your copay at each visit.

For your convenience, you have the option of keeping a credit card on file with the office for your payments.

Any payment taken at the time of service is an estimate and you may later receive a credit or a bill for any balance due.

We will attempt to look up your coverage online but we cannot guarantee what we find. *If following the processing of your claims it is discovered your coverage is less or more than expected your account will be adjusted accordingly.*

If you cannot pay your balance in full, we request you set up an auto-payment plan.

We appreciate prompt payment in full on outstanding bills. If you are surprised with a balance you were not expecting, we request you set up an auto-payment plan. This is convenient for you and allows us to be paid in a timely manner.

If we cannot verify your insurance from the information given us, it is the policy of this office to collect $90 for your initial visit and $45 for visits thereafter until your insurance is verified.

If you have a very high deductible with little chance of your insurance company paying for anything, we request you pay $90 for your initial visit and $45 for visits thereafter.

We will still submit your insurance for you and it may go toward your deductible. If you do not want us to submit it to your insurance, you must sign an Election to Self-Pay Form with our office.

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For Medicare Patients Only

Medicare will pay for some of your chiropractic care only AFTER your deductible has been paid. The deductible for 2024 is $240.

Medicare does NOT pay for exams, x-rays, nutritional supplements, supports/braces/orthotics. The fees for these services will be your responsibility. Auto-payment plans are available for these services if needed.

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Assignment of Benefits

I authorize my insurance company to pay this chiropractor/health center all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the chiropractor/health center to release all information necessary to secure payment of benefits.

Printed Name: _____

Signature: _____Date: _____

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2 McConkey Road, Suite 3, Gray, Maine 04039
Phone: 207-657-5200 Fax: 207-657-5202

Notice of Patient Privacy Policy

The following pages are the Notice of Patient Privacy Policy of this office. It describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully and sign below. If you have any questions about this policy, please ask our Privacy Officer, Fran Dombrowski, DC.

*****

I have reviewed this copy of the Patient Privacy Policy. I understand I may request a copy of this policy now or anytime in the future.

Signature:_____Date:_____

Gray Chiropractic Center

2 McConkey Rd, STE 3
Gray, Maine 04039
PH: 297-657-5200

Notice of Patient Privacy Policy

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 our Privacy Officer or any staff member in our office.

Our Privacy Officer is: Fran Dombrowski, DC

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "**P**rotected **H**ealth **I**nformation" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website graychiro.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

  In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of students.

  For example, we may disclose your protected health information to interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We do not have open therapy/adjusting areas.

  We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

  We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

  Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization

  Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

- *Disclosures of psychotherapy notes*
- *Uses and disclosures of Protected Health Information for marketing purposes;*
- *Disclosures that constitute a sale of Protected Health Information;*
- *Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.*

  You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

  Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

  In the following instance where we may use and disclose your protected health information, you

have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** 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. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

- **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

  Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.

- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. *You have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office*. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. *You may opt out of fundraising communications in which our office participates.*

  Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

  You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

- **You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.

- ***You have the right to be notified by our office of any breech of privacy of your Protected Health Information.***

- **Certain treatments may be performed in a common therapy area and/ or you may find yourself within public areas within the clinic times, but please note private rooms are always available, upon request, for discussing your private health information.**

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. *To file a complaint you may go to: https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html*

Or our office can provide you with a written form in which to file your complaint. You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Fran Dombrowski, DC. You may contact our Privacy Officer or any staff member, including Chris Dombrowski, DC, at the following phone number: 297-657-5200 or on our website: graychiro.com for further information about the complaint process.

This notice was published and becomes effective on December 1, 2023