Gerald T. Lalla
Doctor of Chiropractic

520 Highway 96 West, Suite 200
Shoreview, Minnesota 55126

651-484-8521/Fax 651-484-7374
www.futurehealth-today.com

Personal Information:
Name:_____ Today's Date_____

Social Security #_____-_____-_____ Medicare #_____

Address:_____

City/State/Zip_____

Home Phone:_____ Work Phone:_____

Cell Phone_____ email Address_____

Date of Birth_____ Age_____ Gender (circle): M F Height_____ Weight_____

Marital Status (circle): S M D W No. of Children:_____

Occupation:_____ Employer:_____

Referred by:_____ Past Chiropractic Care? [ ]Yes [ ]No When?_____

Doctor's Name_____ Results_____

Family Medical Doctor_____

Medical Office Address_____

Answering the following questions will give us a profile of the specific stresses placed on your health and allow us to better evaluate the challenges to your health.

Please describe your chief complaint and the effect it has had on your life:_____

_____

_____

_____

List your health Concerns according to severity:	Rate of Severity 1=mild 10=worst	When did the Episode begin?	Did the problem Begin with an injury?	Are symptoms consistent or intermittent?
1.				
2.				
3.				
4.				
5.				
6.				
7.				

If you are experiencing pain, is it _____Sharp _____Dull Ache Does the pain radiate? If so, where_____

_____

Have you done anything for the condition that makes it better or worse? Please describe what it was and whether it made the condition better or worse:_____

_____

_____

Patient Initials_____.

Who have you seen for this condition? _____Chiropractor _____Medical Doctor _____Other

1. Name/Address_____Date_____

What was the diagnosis?_____

What was done? _____

2. Name/Address_____Date_____

What was the diagnosis?_____

What was done? _____

Insurance Company_____ Address_____

Policy No._____Claim No._____ Medicare No._____

Other doctors with whom you are presently treating: _____

_____

Are your present complaints due to an on-the-job-injury?_____Have you made a report of your accident to your employer?___

Do you plan to turn it in to workers' compensation?_____ Are you now or have you ever been disabled (service or work)?

If yes, when?_____How?_____

General History

Check all symptoms you have ever experienced even if they do not seem to be related to your current problem:

GENERAL SYMPTOMS
___Headache
___Dizziness
___Convulsions
___Loss of Sleep
___Fatigue
___Loss of Weight
___Numbness or Pain in arms/legs/hands
___Allergy (What?)
___Backache
___Swollen Joints
___Tremors
___Hernia
___Spinal Curvature

GASTRO-INTESTINAL
___Poor Digestion
___Belching or Gas
___Nausea
___Pain Over Stomach
___Constipation
___Diarrhea
___Colon Trouble
___Hemorrhoids (Piles)

GENITO-URINARY
___Frequent Urination
___Painful Urination
___Bed Wetting
___Inability to Control Urine
___Prostate Trouble

EYE EAR NOSE THROAT
___Poor Vision
___Deafness
___Ear Noises
___Nose Bleeds
___Sore Throat
___Asthma
___Frequent Colds
___Sinus Trouble
___Hives or Allergy
___Eczema

EXERCISE
___None
___Moderate
___Daily

FOR WOMEN ONLY
___Painful Periods
___Excessive Flow
___Irregular Cycles
___Hot Flashes
___Cramps or Backache
___Miscarriage
___Vaginal Discharge
___Pregnant at this time
___Last Pap?_____.

RESPIRATORY
___Chronic Cough
___Spiting Blood
___Spitting Phlegm
___Difficulty Breathing

Habits

___Smoking __Pks/day	___Alcohol __Per day	__Coffee/Caffeine __Cups/day	__Water ____#glasses/day

HAVE YOU HAD ANY OF THE FOLLOWING:

___Alcoholism	___Cancer	___Epilepsy	___Lumbago	___Osteoporosis	___Rheumatic Fever
___Anemia	___Chicken Pox	___Goiter	___Measles	___Pleurisy	___Tuberculosis
___Appendicitis	___Diabetes	___Heart Disease	___Mental Disorder	___Pneumonia	___Venereal Disease
___Arthritis	___Eczema	___Influenza	___Mumps	___Polio	___Whooping Cough

Have you ever had surgery? (Please include all surgeries).

1. Type _____Date_____Doctor_____
2. Type _____Date_____Doctor_____
3. Type _____Date_____Doctor_____
4. Type _____Date_____Doctor_____

Any and all accidents and/or injuries: auto, work related or others:

1. Type _____Date_____Hospitalized?_____

Patient Initials_____.

2. Type _____ Date_____ Hospitalized?_____

3. Type _____ Date_____ Hospitalized?_____

4. Type _____ Date_____ Hospitalized?_____

Have x-rays ever been made of you? If so, when?_____ What type of clinic?_____

What areas of the body?_____

Have you ever had a spinal tap or spinal injection? Yes_____ No____

Have you ever been knocked unconscious? Yes_____ No____

Have you ever had a lapse of memory? Yes_____No____

Do you feel safe in your living situation?_____

Please list any medications and the dosage, either prescription or over-the-counter, that you are now taking: _____

_____

_____

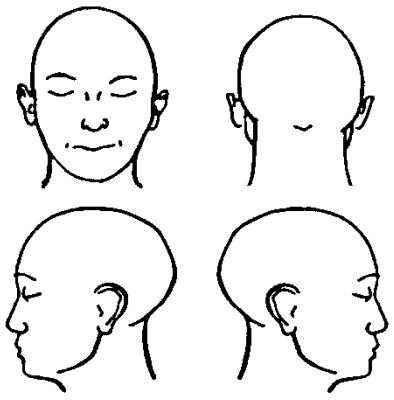
Are you presently, or have you ever been involved in a malpractice suit of any type? Yes ____ No____. If so, please explain briefly: _____

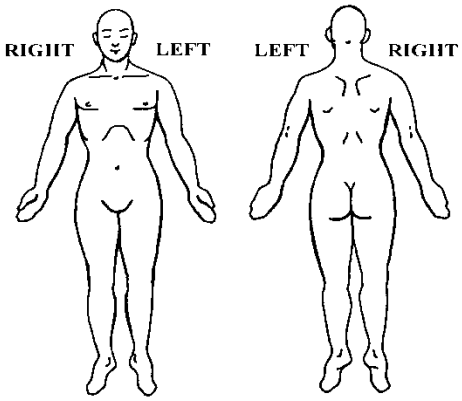
Would you like to have a person of the same sex in attendance during your consultation/ examination? Yes____ No _____

Family History: Has any member of your family suffered with any of the following health issues: (Please indicate relationship.)

Heart	
Diabetes	
Kidney	
Cancer	
Stroke	
Back	
Osteoporosis	

Please indicate on the following chart areas of your body where you have pain or discomfort.





Patient Initials_____.

"I understand and agree that the clinic does not bill patients for care, and patients are expected to pay for their services on the day that they are rendered unless other arrangements have been made prior to care. In the case of an auto collision or worker's compensation injury, we will bill the insurance carrier. I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. The clinic's policy is to recommend what is best for each patient. What an insurance company may or may not pay is between the patient and the patient's insurance company, and the clinic will not and cannot set its recommendations by what an insurance company's particular policy may be. I believe that it is my constitutional right to accept or reject any treatment or examination offered to me whether it is considered "orthodox or unorthodox, medically necessary or unnecessary, investigational or experimental".

Any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand and agree that if any amount on my account is 30 days or older, a 1% per month finance charge will be added to that balance. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

The Doctor has advised me that manipulation of the cervical spine (neck) could possibly cause a stroke. The Doctor will perform tests and listen to the circulation in my neck and if my responses are normal and do not indicate any precursors to stroke, I hereby authorize the Doctor to manipulate my neck and any other area of my spine and I resolve him/her of responsibility should a stroke occur. I hereby authorize the Doctor to treat my condition as he deems appropriate and to release information to my insurance company. The Doctor has my permission to contact other health care providers that may be involved in my health care. It is understood and agreed that the x-ray negatives made of me will remain the property of the Doctor's Office and copies of said negatives, as well as other records, will be made for me or my designate at a nominal charge, if so requested. I (the patient) also agree that I am responsible for all bills incurred at this office.

I swear that the Doctor has informed me that some of my tests may be considered unorthodox and I have not engaged the services of the Doctor for any hidden purposes, "state or federal harassment or the filing of a malpractice suit". The Doctor will not be held responsible for any pre-existing condition, nor for any diagnosis that he has not made. Finally, I understand that the program may consist of chiropractic, acupuncture, other alternative health care methods, and metabolic and nutritional guidance. I have the right to reject this care at any time and I have not been advised against any medical examination and/or treatment."

*Patient's Signature:*_____ *Date:*_____

*Guardian or Spouse's*_____ *Date:*_____

*Signature Authorizing Care*_____ *Date:*_____

The Lalla Clinic

Gerald T. Lalla
Doctor of Chiropractic

520 Highway 96 West, Suite 200
Shoreview, Minnesota 55126
(651)484-8521 Fax(651)484-7374

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.

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of _7/1/03, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

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 at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. TREATMENT, PAYMENT, HEALTH CARE OPERATIONS: You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows:

> Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment 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, and other business operations.

B. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. 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 permitted by this Notice.

C. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your 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 only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

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

E. USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, 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.

G. LAW ENFORCEMENT/NATIONAL SECURITY: Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

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

PATIENT RIGHTS:

A. ACCESS TO RECORDS: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we will charge you $0.75 for each page, a fee of no more than $10 for the labor of copying the records, and postage if you want the copies mailed to you. (Note: We will not charge you any fees for retrieving or handling the information or for processing the request.) The per page dollar amount does not apply to copies of x-rays, for which we will not charge you more than the actual cost of reproducing the x-rays. If you request an alternative format, we will charge a reasonable 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 at the end of this Notice if you are interested in receiving a summary of your information instead of copies. If you request copies in connection with your application for social security benefits, we will not charge you any fee.

B. ACCOUNTING OF CERTAIN DISCLOSURES. Upon written request, 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 other activities authorized by you, for the last 6 years, but not before April 14, 2003. 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.

C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.
D. AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. ELECTRONIC NOTICES. If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint 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 us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to Diane Lalla at the address or phone number above.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Gerald T. Lalla, D.C., which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

X_____ **X**_____

Date Signature

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ☐ Patient Unavailable
- ☐ Patient Physically Unable
- ☐ Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply) :

- ☐ Personally ☐ Mail ☐ Phone Follow Up
- ☐ Other: _____

_____ _____

Date Signature

Authorized Persons List

In accordance with the Privacy Rules provided to me, I understand the conditions in which Dr. Lalla may discuss my care and/or provide protected medical information to others. In addition, I certify that Dr. Lalla may share this protected information with the following person(s):

Name of person	Patient signature	Date
Name of person	Patient signature	Date
Name of person	Patient signature	Date

Gerald T. Lalla, D.C.
Consent for Purposes of Treatment, Payment and Healthcare Operations

I, , consent to Gerald T. Lalla, D.C.'s use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

X_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

Date:_____

_____
Description of Personal Representative's Authority