LOVA Health

6744 Clayton Rd. Ste.206 St. Louis, MO 63117 314-529-1941

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home # ( ) _____Work # ( ) _____ Cell # ( ) _____

Email address: _____ Male _____ Female _____

Birthdate: _____ Age: _____ Occupation: _____

Employer Name and Address: _____

☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Widowed

Spouse/Partner's Name _____# of children_____

Have you seen a Chiropractor before? ☐ Yes ☐ No If yes, when was your last visit? _____

Do you prefer: ☐ Text message **OR** ☐ Email reminders? Who is your cell phone company? _____
When would you like to receive your reminders? ☐ 1 Hour ☐ 2 Hours ☐ 4 Hours ☐ 1 Day

How did you hear about us? ☐ Google ☐ Insurance Website ☐ Other Website _____

☐ Friend/Family Member _____ ☐ Presentation _____ ☐ Flyer _____

☐ Another Doctor _____ ☐ Other _____

CMS (Centers for Medicare and Medicaid Services) requires providers to report both race and ethnicity

Race (MUST Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (MUST Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage (i.e. 5mg)	Frequency (i.e. once a day)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Please check all conditions you have currently or have had in the past, even if they do not seem related to your current problem.

☐ HIV/Aids	☐ Allergies	☐ Anemia	☐ Anorexia/Bulimia
☐ Appendicitis	☐ Arthritis	☐ Asthma	☐ Autoimmune Problems
☐ Bleeding Disorder	☐ Bowel Disease (IBS, Crohn's, etc)	☐ Bronchitis	☐ Cancer: _____
☐ Depression	☐ Diabetes	☐ Emphysema	☐ Epilepsy
☐ Fractures/Dislocations	☐ Heart Disease	☐ Hernia	☐ Herniated Disc
☐ High Cholesterol	☐ Kidney Disease	☐ Liver Disease/Hepatitis	☐ High Blood Pressure
☐ Migraine Headache	☐ Miscarriage	☐ Multiple Sclerosis	☐ Osteoporosis
☐ Pacemaker	☐ Polio	☐ Pneumonia	☐ Prostate Problems
☐ Rheumatoid Arthritis	☐ Scoliosis	☐ Stroke	☐ Thyroid Problems
☐ Tuberculosis	☐ Ulcers	☐ Urinary Tract Infections	☐ Whiplash
☐ STD	☐ Psychiatric Problems	☐ Alcoholism/Chemical Dependency	

Please check all conditions all conditions for which you have a family history, even if they do not seem related to your current problem.

☐ HIV/Aids	☐ Allergies	☐ Anemia	☐ Anorexia/Bulimia
☐ Appendicitis	☐ Arthritis	☐ Asthma	☐ Autoimmune Problems
☐ Bleeding Disorder	☐ Bowel Disease (IBS, Crohn's, etc)	☐ Bronchitis	☐ Cancer: _____
☐ Depression	☐ Diabetes	☐ Emphysema	☐ Epilepsy
☐ Fractures/Dislocations	☐ Heart Disease	☐ Hernia	☐ Herniated Disc
☐ High Cholesterol	☐ Kidney Disease	☐ Liver Disease/Hepatitis	☐ High Blood Pressure
☐ Migraine Headache	☐ Miscarriage	☐ Multiple Sclerosis	☐ Osteoporosis
☐ Pacemaker	☐ Polio	☐ Pneumonia	☐ Prostate Problems
☐ Rheumatoid Arthritis	☐ Scoliosis	☐ Stroke	☐ Thyroid Problems
☐ Tuberculosis	☐ Ulcers	☐ Urinary Tract Infections	☐ Whiplash
☐ STD	☐ Psychiatric Problems	☐ Alcoholism/Chemical Dependency	

List any non-medication allergies you currently have: _____

List any surgeries you have had and the date: _____

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

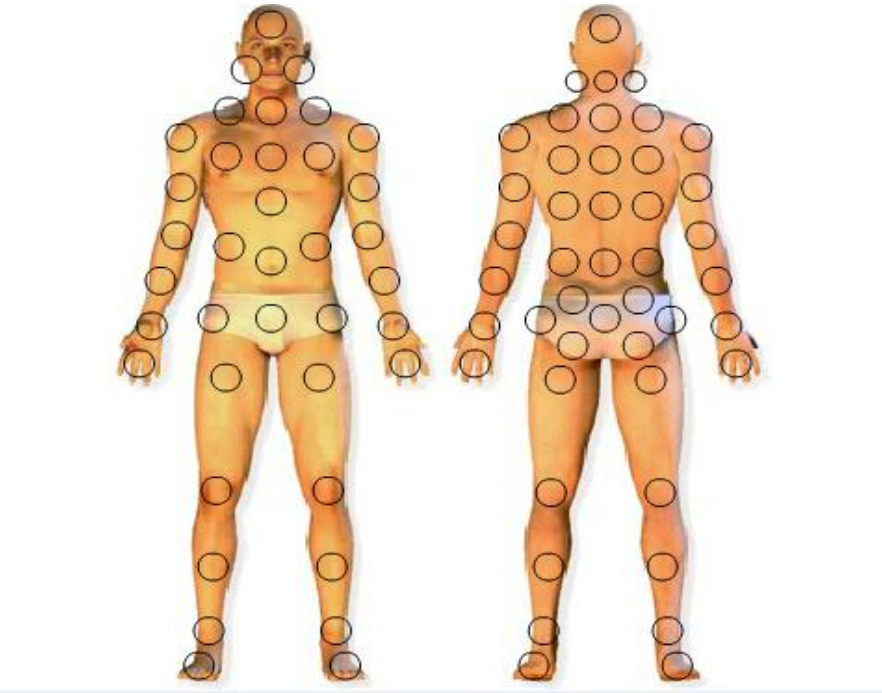
Patient Signature _____ Date _____

Parent/Guardian Signature: _____ Date _____

Name _____Date _____

Patient Complaint Form

Mark an X on your areas of discomfort.



How would you rate the level of discomfort right now on a scale of 1-10 with 1 being mild pain and 10 being the worst possible pain (Circle One)?

1 2 3 4 5 6 7 8 9 10

What is the frequency of the discomfort you are feeling? (Circle One)

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How would you rate the discomfort *at its worst*? (Circle One)

1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort *at its best*? (Circle One)

1 2 3 4 5 6 7 8 9 10

Describe the onset of the discomfort? (Circle One)

Gradual Sudden

When did the discomfort begin?

_____ hours ago _____ days ago _____ weeks ago _____ months ago _____ years ago

Since the problem began, have the symptoms been getting better, worse, or have they been relatively unchanged? (Circle One)

Better Worse Unchanged

What makes the discomfort worse? (Check all that apply)

☐ Bending	☐ Carrying	☐ Cleaning	☐ Climbing	☐ Cooking	☐ Coughing	☐ Crawling
☐ Cycling	☐ Dressing	☐ Driving	☐ Eating	☐ Exercising	☐ Gardening	☐ Jumping
☐ Kneeling	☐ Lifting	☐ Lying Down	☐ Medications	☐ Golfing	☐ Tennis	☐ Pulling
☐ Pushing	☐ Reaching	☐ Resting	☐ Running	☐ Sex	☐ Sitting	☐ Sleeping
☐ Sliding	☐ Sneezing	☐ Standing	☐ Stooping	☐ Stretching	☐ Swinging	☐ Turning
☐ Twisting	☐ Typing	☐ Walking	☐ Working	☐ Other _____		

What relieves the discomfort? (Check all that apply)

☐ Bending	☐ Carrying	☐ Cleaning	☐ Climbing	☐ Cooking	☐ Coughing	☐ Crawling
☐ Cycling	☐ Dressing	☐ Driving	☐ Eating	☐ Exercising	☐ Gardening	☐ Jumping
☐ Kneeling	☐ Lifting	☐ Lying Down	☐ Medications	☐ Golfing	☐ Tennis	☐ Pulling
☐ Pushing	☐ Reaching	☐ Resting	☐ Running	☐ Sex	☐ Sitting	☐ Sleeping
☐ Sliding	☐ Sneezing	☐ Standing	☐ Stooping	☐ Stretching	☐ Swinging	☐ Turning
☐ Twisting	☐ Typing	☐ Walking	☐ Working	☐ Other _____		

What is the quality of the discomfort? (Check all that apply)

☐ Aching	☐ Anguish	☐ Burning	☐ Continuous	☐ Deep	☐ Depression	☐ Despair
☐ Discomfort	☐ Dull	☐ Frequent	☐ Intense	☐ Intermittent	☐ Mild	☐ Moderate
☐ Numb	☐ Occasional	☐ Pain	☐ Random	☐ Severe	☐ Sharp	☐ Shooting
☐ Throbbing	☐ Tingling	☐ Tightness	☐ Other _____			

When is the discomfort at its worst? (Check One)

☐ In the morning ☐ In the afternoon ☐ In the evening ☐ Just before bed

Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

Lev Furman, D.C.

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 AND SIGN.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required 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.

Uses And Disclosures Of Protected Health Information Based Upon Your Written Consent
You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, 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 may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic 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.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine or voice mail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open area where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office" or office bulletin board unless you specifically request us not to do so. Your private information will be used when we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency.

We may 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 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 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 may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

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. You nay revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic 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 Consent, Authorization or Opportunity to Object

We may use and disclose your protected health care information in the following instances. 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 chiropractor 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.

NOTICE OF PRIVACY PRACTICES

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 chiropractic 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 a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. 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 relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your chiropractor or another chiropractor in the practice is required by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization:
When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

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.

You have the right to inspect and copy your protected health information.

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, health operations or additional uses listed above in paragraph 8. 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 state the specific restriction requested and to whom you want the restriction to apply.

Your chiropractor is not required to agree to a restriction that you request. If your chiropractor 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 chiropractor 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.

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 this request. Please make this request in writing to our Privacy Contact.

You may have the right to have your chiropractor 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.

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.

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.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

Privacy Contact: Dr. Lev Furman 6744 Clayton Rd. Suite 206 St. Louis, MO 63117 P: 314-529-1941

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Lev, Furman, D.C., staff, and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices.

"You May Refuse To Sign This."

Printed Patient Name _____ Date _____

Signature _____

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____

LOVA Health

Office Policies

The following policies will help you and your family to receive all the benefits chiropractic offers and help us to achieve our mission.

1. **Lengthy or Confidential Questions** - If you have anything lengthy or confidential to discuss with the doctor, please let the front desk know and we will be happy to have the doctor call you, e-mail you or we can arrange a special appointment for you to speak privately with the doctor.

2. **Missed Appointments -** If for any reason you must miss your scheduled appointment, please call as soon as possible so that we can reschedule it within the same week in order to keep your spinal correction on track. If you miss your appointment and do not call that day, there will be a fee of $25 that will be charged to your account at the end of the business day.

3. **Cell Phone Policy** – Please help us to keep a peaceful, relaxing environment by refraining from cell phone use in our office. If you must take a call, please restrict usage to outside the office.

4. **Severe Weather** - The office may close in the event of severe weather. In case of extreme weather conditions please call first to be sure the office is open.

5. **Insurance –** Verification of your insurance benefits is not a guarantee of payment. You will be responsible for any unpaid balance. If we submit your insurance claims, the amount due will be based upon our best estimate according to the information provided us by your insurance company. If claims process differently than expected, we will update your amount due according to the information provided on your insurance company's Explanation of Benefits. All co-payments are due at the time of service.

Signature: _____

Office Hours

Weekdays 9:00am – 6:00pm

*Office Hours are subject to change.

6744 Clayton Rd. Suite 206

St. Louis, MO 63117

314-529-1941

Phone: 314-529-1941
6744 Clayton Rd. Suite 206 St. Louis, MO 63117

Informed Consent

Patient Name: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
(Initial the statement below OR initial each procedure to which you are consenting)

__I consent to all of the procedures listed below

If not consenting to all procedures, initial each procedure below to indicate consent:

__spinal manipulative therapy	*__palpation*	*__vital signs*
__range of motion testing	*__orthopedic testing*	*__basic neurological testing*
__muscle strength testing	*__postural analysis*	*__EMS*
__hot cold therapy	*__radiographic studies*	*__Acupuncture/Auriculo*

_____
_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications including but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers of remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRAITE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Lev Furman and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____
Patient's Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

Dated: _____

L. Furman, D.C.
Doctor's Name

_____
Signature