# GREENHANDS HEALING CENTER

1085 Tunnel Rd, Suite 7B
Asheville, NC 28805
828-298-4500
828-298-4575 fax

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 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 reasonable basis to believe the information can be used to identify me.

- I consent to GreenHands Healing Center use and disclose of my Protected Health Information for the purposes of providing treatment to me and relating to payment of services rendered to me. Health care 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 may be considered upon my consent as evidence by my signature on this document.

- Your chiropractor and staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are authorizing us to contact you with these reminders and information.

- In this office, there may be a time when it is necessary for open therapy. This means that in the uncommon case one therapy room may have multiple therapies in use.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone viewing it and may no longer be protected under the privacy rules.

You may inspect or copy information used under this authorization. This notice is effective as of the date below. This authorization will expire seven years after the date which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I also may request a copy of this authorization.

I understand I have the 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 the Physician or the Practice has acted in reliance of this consent.

_____ _____
Patient name printed Date

_____ _____
Patient signature Authorized provider representative

_____ _____
Personal representative printed Personal representative signature

_____
Description of personal representative's authority to act for the patient
(parent, guardian, etc.)

# GreenHands Healing Center

## David Greenspan, D.C.

CONFIDENTIAL PATIENT INFORMATION

Date: _____ Name you like to be called: _____
Name: _____ Sex: M ___ F ___ SSN: _____
LAST FIRST INIT.
Address: _____ City: _____State: _____ Zip:_____
Home Phone # _____ Cell Phone # _____ **Email: _____**
Date of Birth: _____ Age: _____ Marital Status: S___ M ___Other ____ Children's ages: _____
Patient Employed by: _____ Phone #: _____
Spouse Name: _____ Spouse DOB: _____ Spouse Employer: _____
**Whom may we thank for referring you to our office? _____**
**Have you previously been a patient of Dr. David Greenspan's? _____**
Your family physician:_____ Phone #: _____
Whom may we contact in case of emergency: _____ Phone #: _____

**PRIMARY INSURANCE** *please present insurance card(s)*

Name of Insurance Company: _____
Primary Policy Holder's Name: _____Policy Holder's DOB: _____

**SECONDARY INSURANCE**

Name of Insurance Company: _____
Primary Policy Holder's Name: _____ Policy Holder's DOB: _____

Who is responsible for this bill? _____
How will you be paying today? Cash ____ Check ____ Credit Card _____

*I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.*

_____ _____
Signature Date

_____ _____
Parent (if minor) Date

**MEDICAL HISTORY:** (if any following are relevant to your medical history, please circle all that apply)

| | | | | |
|---|---|---|---|---|
| Cancer | Muscular Dystrophy | Rheumatic Fever | Carotid Artery Disease | Pacemaker |
| Polio | Multiple Sclerosis | Scarlet Fever | Digestive Disorders | AIDS |
| Tuberculosis | Convulsions | Nervousness | Sinus Trouble | Hepatitis |
| High Blood Press | Epilepsy | Asthma | Backaches | Venereal Disease |
| Heart Trouble | Concussion | Dizziness | Numbness | Diabetes |
| Aneurysm | German measles | Arthritis | HIV/ ARC | Bowel Dysfunction |

**Notes:** _____
Date of last physical exam: _____ List all Rx medications (including quantity, frequency & dosage):_____
_____
Are you allergic to any medication? YES __ NO __ (if YES please list and indicate reactions such as nausea, rash, difficulty breathing):
_____
Are you pregnant? _____ Date of last menstrual period: _____
List any surgeries and dates: _____

Your present complaint (how often does it occur, for how long, and length of time you have had it):

_____

_____

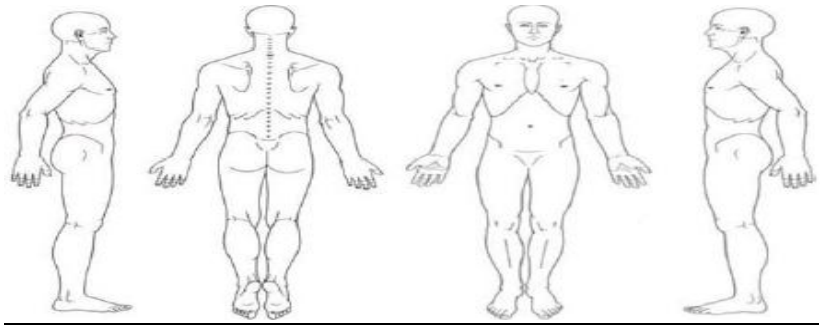
How do these conditions interfere with your daily activities? _____

_____

_____

Other doctors seen for this condition: _____

Indicate where you have pain or other symptoms:



How often do you experience your symptoms?

| | |
|---|---|
| Constantly | (76-100% of the day) |
| Frequently | (51-75% of the day) |
| Occasionally | (26-50% of the day) |
| Intermittently | (0-25% of the day) |

What describes the nature of your symptoms?

| | |
|---|---|
| Sharp | Tingling |
| Dull ache | Burning |
| Numb | Shooting |

During the past 4 weeks...

a. Indicate the average intensity of your symptoms on a scale of 1-10:

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| (None) | | | | | | | | | | (Unbearable) |

b. How much has pain interfered with your normal work?

All of the time Most of the time Some of the time A little of the time None

c. How much has pain interfered with play?

All of the time Most of the time Some of the time A little of the time None