Authorization to Call or Leave Messages

In accordance with HIPAA regulations, we at the CranioSacral Center of the Carolinas need to know in writing what phone number(s) we may call to speak with you or to leave a message. Most calls will be regarding scheduling, however, an occasional call may be regarding your condition. Below are commonly used phone types, with spaces for you to provide the number. *Please provide only those numbers that we have permission to use.*

Patient Name: _____

My home: _____

My work: _____

My cell: _____

The best number to reach me at in case of last-minute scheduling changes or other reason is my ( ) Home; ( ) Work; ( ) Cell *(Please check one)*

If you cannot reach me at the above numbers, please contact:

Name: _____ Relationship: _____

Home #: _____

Work #: _____

Cell #: _____

Parent/Guardian/Personal Representative Phone Numbers:

Parent/Guardian/Personal Rep. (1) _____
(Name & Relationship to Patient)

Home # _____ _ Work # _____ Cell# _____

Parent/Guardian/Personal Rep. (2) _____
(Name & Relationship to Patient)

Home # _____ Work # _____ Cell # _ _____

Patient or Guardian Signature _____ **Date**_____

Patient's Authorization to Release Information

I, _____, authorize _____
to share and/or release medical information to _____.
I understand that I may remove this authorization at any time by so requesting in writing.

_____
Signature of Patient

Date: _____

The CranioSacral Center of the Carolinas
1934 North Pleasantburg Dr. • Greenville, SC 29609
Phone: 864-232-7949 - Fax: 370-7073

The CranioSacral Center of the Carolinas

1934 North Pleasantburg Drive, Greenville, SC 29609
P.O. Box 5703, Greenville, SC 29606
Phone: 864-232-7949 Fax: 370-7073

Carol Ball, OTR/L, CST
Tammy Calder, OTR/L

CANCELLATION POLICY

When you make an appointment with our office, you are reserving time to work on your health needs. If you find that you are unable to make it to your appointment and need to cancel or reschedule, we ask that you give no less than 24 hours advance notice. We often have a list of patients waiting for cancellations to schedule appointments, and with sufficient notice from you we can avoid your time slot going unfilled. Accordingly, you will be charged for the appointment if you give less than the required 24-hour notice.

Please note that if you are more than 15 minutes late for your appointment, you will have to reschedule it for a later time and the cancellation policy will apply.

We understand that emergencies arise and will consider these on a case-by-case basis.

By signing this form, you, the Patient, acknowledge that you have read and agree to this Cancellation Policy.

_____
Patient's Name

_____
Patient's Signature

Date _____

Welcome to Our Office

Confidential Patient Information

Name _____ Date _____

Address_____ City:_____State _____Zip _____

Phones - Home ( )_____ Work ( )_____ Cell ( )_____

Email _____ Referred By _____

Spouse Name _____ Phone ( ) _____

Age: ____ Birth Date: _____ Sex: M / F Marital Status: S / M / W / D Children: Y / N Ages:_____

Occupation _____Employer & Address _____

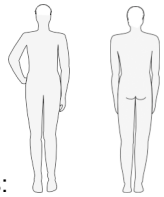
Guardian Name _____ Guardian's Phone No. _____

Emergency Contact Name _____ Phone No._____

List main problems: Please list problems below and where the problem occurs in body (R,L)

_____

_____



Mark areas of pain on diagrams:

1. _____

Intensity 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

Frequency Never Rarely 1x month 1x week Daily

Duration 1-5 minutes 5-30 minutes 1-2 hours ___ Hours Continuously

Does this interfere with work? _____ exercise?_____ self care? _____ sleep? _____ 2.

_____

Intensity 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

Frequency Never Rarely 1x month 1x week Daily

Duration 1-5 minutes 5-30 minutes 1-2 hours ___ Hours Continuously

Does this interfere with work? _____ exercise?_____ self care? _____ sleep? _____

3. _____

Intensity 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

Frequency Never Rarely 1x month 1x week Daily

Duration 1-5 minutes 5-30 minutes 1-2 hours ___ Hours Continuously

Does this interfere with work? _____ exercise?_____ self care? _____ sleep? _____

Please list **Surgeries** (type of surgery and date). Include major **dental** work. _____

_____

_____

Please list **Accidents or Falls** (type and date) _____

_____

_____

Please list **Medications** _____

Other Doctors you have seen for this condition _____

Have you been treated for any other condition in the past year? If yes, please describe. _____

_____

Any additional information or remarks _____

_____

Other Information

Height _____ Weight (Now) _____ (One year ago) _____ Known Allergies _____

_____

Habits

Do you smoke?	Y / N	What? _____	How many per day _____	Since when? _____
Other tobacco products?	Y / N	What? _____	How much per day? _____	Since when? _____
Drink Coffee?	Y / N	Cups per day _____	Drink Caffeinated tea? _____	Cups per day _____
Alcoholic Beverages?	Y / N	Avg. no. per week _____	Mostly what? _____	

Exercise

What sports have you played seriously? _____

What sports do you enjoy now? _____

Are you in training for a particular sport? Y / N Please describe. _____

Describe your exercise program. _____

_____

Please if you could, do not wear any scented lotions or perfumes due to sensitivities to others at the time of your visit.

Thank you.

Client Authorization

I authorize the therapists of **The CranioSacral Center of the Carolinas,** Carol Ball, OTR/L, CST or Tammy Calder, OTR/L to render appropriate treatment. I recognize and agree that I have the right to refuse treatment or terminate services at any time. I understand that no guarantee of results has been given to me.

_____ _____

Signature of Patient or Guardian Date

_____

Name of Patient or Guardian (please print)

Please mark a **C** for any symptom or condition you **currently** have, and a **P** for any symptom or condition you have had in the **past**.

Sleep Habits

___ Insomnia
___ Oversleeping
___ Wake up frequently
___ Unable to sleep in certain positions

Digestive system

___ Heartburn
___ Feeling bloated
___ Hiatal Hernia
___ Nausea
___ Ulcer
___ Loss of Appetite
___ Constipation
___ Diarrhea
___ Irritable Bowel Syndrome
___ Hemorrhoids
___ Difficulty swallowing
___ Stomach pain

Muscles and Joints

___ Stiff or painful upon waking
___ Painful feet
___ Back pain
___ Shoulder and neck pain
___ Leg pain
___ Arm pain
___ Swelling
___ Cramps
___ Unable to hold adjustments

Well Being

___ Depressed mood
___ Fatigue, low energy
___ Difficulty concentrating
___ Nervous exhaustion
___ Anxiety or worry
___ Frequent crying
___ Addictions
___ Eating Disorder

Urinary System

___ Urinary problems
___ Frequent urination at night
___ Kidney or bladder disease

Respiratory System

___ Breathing problems
___ Asthma
___ Allergies
___ Frequent colds
___ History of Bronchitis
___ Sore throat
___ Coughing spells

Circulatory System

___ High blood pressure
___ Low blood pressure
___ Cardiac procedures
___ Varicose veins

Nervous System and Senses

___ Dizziness / Vertigo
___ Ringing in ears
___ Change in sense of taste
___ Vision problems
___ Numbness
___ Tingling
___ Burning sensation

Endocrine System

___ Low blood sugar
___ Diabetes
___ Low thyroid
___ Hyperthyroidism

Women Only

___ Irregular menses
___ PMS
___ Complete hysterectomy
___ Partial hysterectomy
___ Other gynecological procedures
___ On hormone replacement
___ Lumpy breasts
___ Breast implants
___ Fibroid tumors
___ On hormone replacement

Men Only

___ Weak or slow urine stream
___ Prostate trouble
___ Trouble with erections

Children Only

___ Delay in developmental skills
___ Impulsive
___ Difficulty attending to tasks
___ History of poor bottle feeding
___ Sleeping difficulties
___ Difficulty following directions
___ Hand-eye coordination problems
___ Behavior problems
___ Problems while in womb
___ Problems during delivery

_____ _____

Patient signature Date

Notice to Our Patients About Our Privacy Practices
and
Your Rights Regarding Your Health Information

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

We at the CranioSacral Center of the Carolinas pledge to give you the highest quality health care and to have a relationship with you that is built on trust. This trust includes our commitment to respect the privacy and confidentiality of your health information. This Notice is being given to you because federal law gives you the right to be told ahead of time about:

- How we will handle your health information
- Your rights concerning your health information
- Our duties concerning your health information

HOW WE WILL HANDLE YOUR HEALTH INFORMATION

Health information means information you give about yourself and your health when you become our patient. This information, along with the record of the care you receive, is your "health information." This is kept in paper form in your chart and in some cases in electronic form on the computer.

We use your health information within our office and may in some cases share it with others outside our office, in order to give you excellent care. We may legally use and share your health information, without asking for your specific permission, for:

Treatment – This means how we provide and manage your health care and related services, and might include coordination of your care with other providers, to ensure that everyone caring for you has the information they need where applicable.

Payment – This means sharing your health information in order to bill and collect payment for health services we give you, where applicable.

Health Care Operations – These are activities related to the business aspects of operating the CranioSacral Center and carrying out our mission and could include storing your information on computers, conducting quality assessment and improvement activities, auditing, and financial record-keeping.

Other purposes including complying with state and federal laws and regulations, required reporting to public health and child protection authorities, for legal and administrative proceedings, law enforcement purposes, to avert a serious threat to health or safety and other permissible purposes.

All those we may share your information with, must also take steps to keep your health information private. We will disclose only the minimum amount of information necessary to achieve the required purpose. We will utilize physical safeguards for your

information including shredding of personal documents not in use and retaining records in a secure location. We will train all our staff to comply with this Notice and our privacy practices.

We may use your health information to contact you:

- At the address and telephone numbers you give to us, including leaving messages at the telephone numbers, about scheduled or cancelled appointments, billing or payment matters, procedure assessments and test results
- With other information about care issues, treatment choices and follow-up care instructions and other health-related benefits and services that may be of interest to you.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION AND HOW TO EXERCISE THEM

You have the right to ask for restrictions on the use and sharing of your health information for treatment, payment or health care operations, including restrictions on using this information to notify you about appointments, etc. For example, you may ask that we not contact you with appointment reminders by telephone, or only call at you work or cell telephone number rather than home. When we ask you to provide us with information necessary for contacting you, it is your responsibility to do so and to make sure the information is accurate and current. We are not required to agree to your request for restrictions but will make reasonable efforts to honor reasonable requests. You may not ask us to restrict uses and sharing of information that we are legally obligated to make.

You have the right to look at and get a copy of the health information that we keep of your medical treatment and bills. You must ask for this in writing. We will respond within thirty (30) days. If you ask for a copy of your records, you will be charged a fee. If we deny your request, we will explain the reasons in writing and tell you what rights you have, if any, to a review of the denial.

You have the right to ask us to change your health information relating to your treatment and bills if you think there has been a mistake or information is missing. You must make this request in writing and give the reason you want the change. We have 60 days to respond to your request, and a 30-day extension of that with notice to you of why we need the extension and when you may expect a response. We may deny your request, and if so must provide you with a written statement with the reasons for the denial and what other steps are available to you.

You have the right to get a record of the times that your health information was shared, upon written request, except when the sharing was for treatment, payment or health care operations, or if you gave permission, or the sharing was with persons involved in your care or with you about your health care, or when the law required us to share the information. You may request this as far back as April 14, 2003. The list you will get will include the date, name, address, if known of the person who received the information, a brief description of the information given and statement of why the information was shared. We have 60 days to respond to your request and are allowed a

30-day extension upon notice to you including the reasons for the extension and date you may expect the information. You are entitled to one free request in any 12-month period.

You have the right to ask for a paper copy of this Notice from the contact listed at the end of this Notice.

OUR DUTIES CONCERNING YOUR HEALTH INFORMATION

We are required by law to keep your health information private. We are required to give people notice of our legal duties and privacy practices concerning your health information. We must abide by the terms of the Notice currently in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. If so, the updated Notice will be posted in our office and on our website for public inspection.

HOW TO COMPLAIN IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED.

If you think we may have violated your privacy rights or you disagree with any action we have taken with regard to your health information we want you, your family or your guardian to speak with us. If you complain to us, your care will not be affected in any way. It is our goal to give you the best care while respecting your privacy.

You may file a complaint by contacting any member of our staff at 1934 N. Pleasantburg Drive, Greenville, SC 29601, 864-864-232-7949. You may also send a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, DC 20201, (202) 619-0257, Toll Free: 1-877-696-6775. We will take no retaliatory actions against you if you file a complaint about our privacy practices.

EFFECTIVE DATE OF THIS NOTICE: This notice is effective June 18, 2008.

****

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have been given a copy of this Privacy Notice and have been given an opportunity to review it and ask any questions I might have about it and what it means to me.

_____
Patient or Representative Name (Please Print)

_____
Patient or Representative Signature

Date: _____