R.A. Dr. Roberto Arias
Chiropractic Physicians

ACTUALIZACION DEL PACIENTE

Favor de completar este cuestionario. Esta informacion formara parte de su expediente personal

Nombre: _____ Fecha:_____/_____/_____

Tel. Casa o celular: _____ Tel. Trabajo:_____

Seg. Social:_____ Fecha de nacimiento: _____/_____/_____

Correo electronico (Email):_____

Hubo algun cambio de direccion: _____ Si _____ No

Direccion nueva: _____

Cuidad: _____ Estado:_____ Codigo postal:_____

Describa en sus propias palabras la nueva condicion que esta experimentando: _____

_____

_____

Hace cuanto tiempo ha tenido esta condicion: _____

_____

Ha tenido esta condicion en el pasado? _____

Alguna posicion aumenta el dolor?_____

Alguna posicion alivia el dolor? _____

Su condicion interfiere con su: _____ Trabajo _____Dormir

_____Rutina diaria _____ Otras

Ha recibido tratamiento por esta condicion de parte de otro doctor o terapista? ____ Si _____No

Informacion del doctor o terapista: _____

Que cree usted le causo esta condicion? _____

_____

_____

Firma: _____ Fecha: _____/_____/_____

Firma del guardian: _____ Fecha: _____/_____/_____

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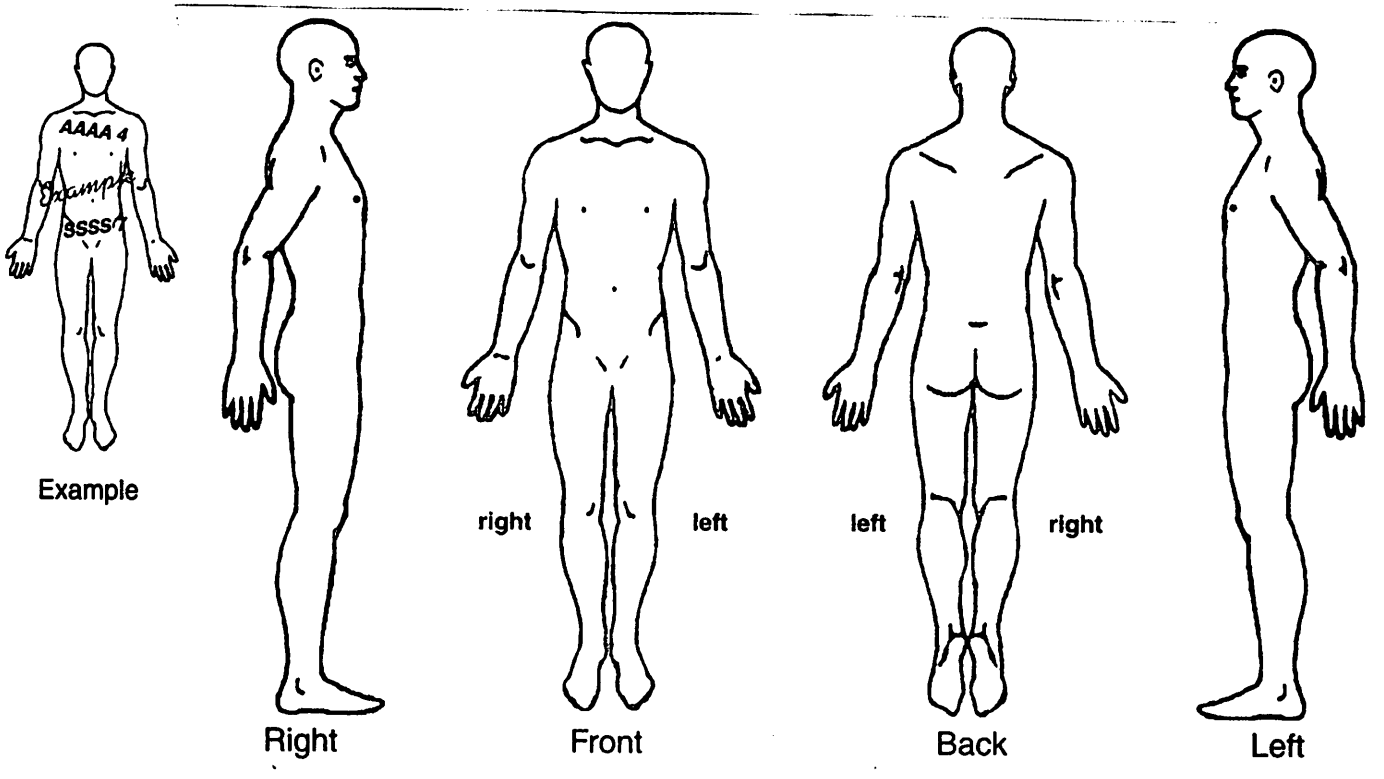
Chiropractic Physician
(407)847-8070
Fax (407)847-6330

Fecha: _____ Nombre: _____

Usando los proximos simbolos, marque el area de su dolor en el cuerpo. En adicion, marque la intesidad de su dolor el la linea a la parte de abajo de la pagina.

Dolor	Quemazon	Adormecimiento	Punzadas	Calambre	Otros
^^^^^^^	wwwwwwwww	OOOO	::::::::::	//////////	x x x x x



No Dolor _____ Mucho dolor

Indique con una linea en el area de nivel de dolor que experimenta

_____

Firma

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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Cuestionario COVID-19

- ¿Le han hecho pruebas de COVID-19 en los últimos 14 días?
  Si____ No____
- Si es así, ¿ha dado positivo o negativo?
  Positivo____ Negativo____
- ¿Ha tenido alguno de los siguientes síntomas?
  - Fiebre o escalofríos Si____ No____
  - Tos Si____ No____
  - Dificultad para respirar Si____ No____
  - Fatiga Si____ No____
  - Dolores musculares o corporales Si____ No____
  - Dolor de cabeza Si____ No____
  - Nueva pérdida del gusto u olfato Si____ No____
  - Dolor de garganta Si____ No____
  - Congestión o secreción nasal. Si____ No____
  - Náuseas o vómitos Si____ No____
  - Diarrea Si____ No____

Si ha dado positivo por COVID-19 en los últimos 14 días, envíenos su hoja de resultados que muestre un resultado negativo.

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