APPLICATION FOR CARE AT ADJUST CHIROPRACTIC

Today's date: _____ HR#: _____

PATIENT DEMOGRAPHICS

Name: _____ Birthdate: _____-_____-_____ Age: _____ ○ Male ○ Female
Address: _____ City: _____ State: _____ Zip: _____
Mailing Address (if different from above): _____
Mobile phone: _____ Work phone: _____ Home phone: _____
E-mail Address: _____ Marital Status: ○ Single ○ Married Do you have insurance? ○ Yes ○ No
Social Security #: _____ Driver's License #: _____
Employer: _____ Occupation: _____
Spouse's Name: _____ Spouse's Employer: _____
Number of Children and Ages: _____
Name & Number of Emergency Contact: _____ _____ Relationship: _____
Name of Previous Chiropractor? _____ ☐ N/A Date of last adjustment? _____
Primary Care Physician: _____ Physician phone number: _____
How did you hear about our office? _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____
Second: _____ Third: _____ Fourth: _____
On a scale of **0** to **10** with **10 being the worst** pain and **zero being no pain**, rate your above complains by ***circling the number:***

Primary or chief complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Fourth complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Primary Complaint:

When did the problem begin? _____ When is the problem at its worst? ○ AM ○ Mid-day ○ PM ○ Late PM
How long does it last? ○ It is constant **OR** ○ I experience it on and off during the day **OR** ○ It comes and goes throughout the week
How did the injury happen? _____
What relieves your symptoms? _____
What makes your symptoms worse? _____
Are you currently under treatment for this condition? ○ No ○ Yes If yes, by whom? _____
Have you suffered with this or a similar problem in the past? ○ No ○ Yes If yes, how many times? _____
When was the last episode? _____ What caused the injury? _____
Has your condition been treated by anyone in the past? ○ No ○ Yes If yes, when? _____ By whom? _____
How long were you under care? _____ Results? ○ Favorable ○ Unfavorable _____

Second Complaint:

When did the problem begin? _____ When is the problem at its worst? ○ AM ○ Mid-day ○ PM ○ Late PM
How long does it last? ○ It is constant **OR** ○ I experience it on and off during the day **OR** ○ It comes and goes throughout the week
How did the injury happen? _____
What relieves your symptoms? _____
What makes your symptoms worse? _____
Are you currently under treatment for this condition? ○ No ○ Yes If yes, by whom? _____
Have you suffered with this or a similar problem in the past? ○ No ○ Yes If yes, how many times? _____
When was the last episode? _____ What caused the injury? _____
Has your condition ever been treated by anyone in the past? ○ No ○ Yes If yes, when? _____ By whom? _____
How long were you under care? _____ Results? ○ Favorable ○ Unfavorable _____

_____ _____ - _____ - _____ _____ _____ - _____ - _____
Patient Signature **Date Completed** **Doctor's Signature** **Date Form Reviewed**

HR#: _____

Third Complaint:

When did the problem begin? _____ When is the problem at its worst? ○ AM ○ Mid-day ○ PM ○ Late PM

How long does it last? ○ It is constant **OR** ○ I experience it on and off during the day **OR** ○ It comes and goes throughout the week

How did the injury happen? _____

What relieves your symptoms? _____

What makes your symptoms worse? _____

Are you **currently under treatment** for this condition? ○ No ○ Yes If yes, by whom? _____

Have you suffered with this or a similar problem in the past? ○ No ○ Yes If yes, how many times? _____

When was the last episode? _____ What caused the injury? _____

Has your condition been **treated by anyone in the past**? ○ No ○ Yes If yes, when? _____ By whom? _____

How long were you under care? _____ Results? ○ Favorable ○ Unfavorable _____

Fourth Complaint:

When did the problem begin? _____ When is the problem at its worst? ○ AM ○ Mid-day ○ PM ○ Late PM

How long does it last? ○ It is constant **OR** ○ I experience it on and off during the day **OR** ○ It comes and goes throughout the week

How did the injury happen? _____

What relieves your symptoms? _____

What makes your symptoms worse? _____

Are you currently under treatment for this condition? ○ No ○ Yes If yes, by whom? _____

Have you suffered with this or a similar problem in the past? ○ No ○ Yes If yes, how many times? _____

When was the last episode? _____ What caused the injury? _____

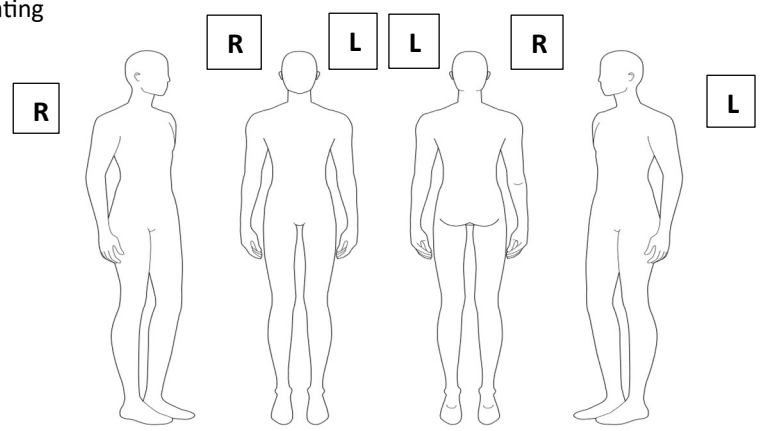
Has your condition been **treated by anyone in the past**? ○ No ○ Yes If yes, when? _____ By whom? _____

How long were you under care? _____ Results? ○ Favorable ○ Unfavorable _____

PLEASE MARK the areas on the body diagram with the following letters to describe your symptoms:

A = **A**ching **B** = **B**urning **N** = Numbness **S** = **S**harp/**S**tabbing

D = **D**ull **T** = **T**ingling **R** = Radiating



LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is/Are your problem(s) the result of ANY type of accident? ○ No ○ Yes If yes, describe _____

Identify **any other injury(s) to your spine (or other joints)**, minor or major, that the doctor should know about: _____

_____

_____

_____	_____ - _____ - _____	_____	_____ - _____ - _____
Patient's Signature	**Date Completed**	**Doctor's Signature**	**Date Form Reviewed**

HR#: _____

PAST HISTORY

Please identify any and all types of jobs/activities you have had in the past that have imposed any physical stress on you or your body:

_____

_____

Current Vitamins/Herbs/Homeopathy remedies/etc.:	Current Medications:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Surgeries What kind?:	Name of surgeon?	How long ago:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Recent Imaging (X-ray CT scan, MRI, NCV, etc.) Of what area?:	Where was the test performed?	How long ago:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Major Illnesses (Childhood or Adult) Please describe: _____

_____

_____

Anything else the doctor should know? _____

_____

FAMILY HISTORY

Does anyone in your family suffer with the same condition(s)? (Grandmother/Grandfather, mother/father, sister/brother, son/daughter)

If yes**, whom**? _____ **Type of condition:** _____

_____ _____

_____ _____

_____ _____

Please list history of any significant family illness, kind of illness, and the family member involved (ex. history of stroke, cancer, diabetes, cardiac conditions, liver disease, kidney disease etc.): _____

_____

_____

Any other hereditary conditions the doctor should be aware of? ○ No ○ Yes : _____

SOCIAL HISTORY

Alcohol: _____ ○ Never ○ Daily ○ Weekends ○ Occasionally

Recreational Drug(s): _____ ○ Never ○ Daily ○ Weekends ○ Occasionally

Exercise: _____ ○ Never ○ Daily ○ Weekends ○ Occasionally

I hereby authorize payment to be made directly to Adjust Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and will remain financially responsible to Adjust Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____ _____ _____ - _____ - _____

Patient's Signature **Date Completed** **Doctor's Signature** **Date Form Reviewed**

PATIENT'S NAME: _____ HR#: _____ DATE: _____

ADJUST CHIROPRACTIC-ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Sit to Stand	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Climb Stairs	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Pet Care	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Extended Computer Use	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Lift Children/Groceries	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Read/Concentrate	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Getting Dressed	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Shaving	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Sexual Activities	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Sleep	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Static Sitting	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Static Standing	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Yard work	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Walking	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Washing/Bathing	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Sweeping/Vacuuming	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Dishes	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Laundry	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Garbage	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Driving	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Other: _____	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

HR#: _____

ADJUST CHIROPRACTIC REVIEW OF SYSTEMS QUESTIONNAIRE

Circle **C** for **CURRENT** condition, **P** for **PAST** condition, and **N** for **NEVER**

Musculoskeletal				**Neurological (cont.)**				**Gastrointestinal**			
TMJ Disorder	C	P	N	Seizures/Epilepsy	C	P	N	Heartburn/Indigestion	C	P	N
Headaches	C	P	N	Narcolepsy	C	P	N	Reflux/GERD	C	P	N
Neck Pain	C	P	N	Parkinson's Disease	C	P	N	Hiatal Hernia	C	P	N
Upper Back Pain	C	P	N	Alzheimer's Disease	C	P	N	Abdominal Pain	C	P	N
Mid Back Pain	C	P	N					Abdominal Bloating	C	P	N
Low Back Pain	C	P	N	**Cardiovascular**				Excessive Gas	C	P	N
Pelvic/Tailbone	C	P	N	Heart Attack	C	P	N	Dark, Tarry Stools	C	P	N
Shoulder Pain	C	P	N	Stroke/CVA Brain	C	P	N	Bright Red Blood in Stool	C	P	N
Elbow/Arm Pain	C	P	N	Transient Ischemic Attack (TIA)	C	P	N	Constipation	C	P	N
Wrist/Hand Pain	C	P	N	Blood Clots	C	P	N	Diarrhea	C	P	N
Hip Pain	C	P	N	Pacemaker	C	P	N	Hernias	C	P	N
Knee Pain	C	P	N	High Cholesterol	C	P	N	Ulcers	C	P	N
Ankle/Foot Pain	C	P	N	High Blood Pressure	C	P	N	Diverticulitis	C	P	N
Scoliosis	C	P	N	Low Blood Pressure	C	P	N	Chron's Disease	C	P	N
Broken Bones	C	P	N	Heart Murmur	C	P	N	Irritable Bowel Syndrome	C	P	N
Dislocations	C	P	N	Irregular or rapid heartbeat	C	P	N	Colon Cancer	C	P	N
Osteoarthritis	C	P	N	Atrial Fibrillation (AFib)	C	P	N	Hemorrhoids	C	P	N
Stiffness/Aching	C	P	N	Angina	C	P	N	Anal Itch	C	P	N
Joint Swelling	C	P	N	Chest pain or discomfort	C	P	N	Rectal/Anal Cancer	C	P	N
Muscle Weakness/Loss of Strength	C	P	N	Congestive Heart Failure	C	P	N	Other Bowel Disorders	C	P	N
Muscle Cramps	C	P	N	Swelling feet/ankles	C	P	N	Appendicitis	C	P	N
Herniated/Bulging Disc	C	P	N	Other Heart Disease	C	P	N	Esophagitis	C	P	N
Osteoporosis	C	P	N	Congenital anomaly	C	P	N	Pancreatitis	C	P	N
Osteopenia	C	P	N	Leg cramps with exertion	C	P	N	Pancreatic Cancer	C	P	N
Gout	C	P	N	Shortness of breath lying down flat	C	P	N	Diabetes Mellitus Type II	C	P	N
				Shortness of breath with exertion	C	P	N				
Neurological				Difficulty breathing at night	C	P	N	**Hepatobiliary**			
Migraines	C	P	N	Bluish color lip/nails	C	P	N	Gallstones	C	P	N
Numbness/Tingling Arms, Hands, or Fingers	C	P	N					Gallbladder problems	C	P	N
Numbness/Tingling Legs, Feet, and Toes	C	P	N	**Endocrine**				Fatty Liver Disease	C	P	N
Weakness of limbs	C	P	N	Excessive thirst	C	P	N	Cirrhosis	C	P	N
Trigeminal Neuralgia	C	P	N	Excessive hunger	C	P	N	Liver Cancer	C	P	N
Bell's Palsy	C	P	N	Cold or Heat Intolerance	C	P	N	Hepatitis A	C	P	N
Difficulty Concentrating	C	P	N	Fatigue	C	P	N	Hepatitis B	C	P	N
Confusion	C	P	N	Hyperactivity	C	P	N	Hepatitis C	C	P	N
Memory Loss	C	P	N	Weight Changes	C	P	N				
Traumatic Brain Injury (TBI)	C	P	N	Thyroid Nodules	C	P	N	**Ears/Nose/Throat**			
Concussion	C	P	N	Goiters	C	P	N	Ear infections	C	P	N
Dizziness	C	P	N	Hypothyroid	C	P	N	Ear Discharge	C	P	N
Vertigo	C	P	N	Hyperthyroid	C	P	N	Tinnitus	C	P	N
Poor Balance or Falling Down	C	P	N	Thyroid Cancer	C	P	N	Hearing Impairment/Loss	C	P	N
Coordination Difficulty	C	P	N	Cushing's Disease	C	P	N	Nosebleeds	C	P	N
Fainting	C	P	N	Hypopituitarism	C	P	N	Sinus Problems	C	P	N
Delayed Motor Skills	C	P	N	Other Pituitary Disorders	C	P	N	Deviated Septum	C	P	N
Speech Delay	C	P	N	Adrenal Disorders	C	P	N	Sore Throat or Tonsillitis	C	P	N
Slurred Speech	C	P	N	Night Sweats				Hoarseness	C	P	N
Inability to Speak	C	P	N					Difficulty Swallowing	C	P	N
Diabetic Neuropathy	C	P	N								

_____ _____ - _____ - _____ _____ _____ - _____ - _____

Patient's Signature **Date Completed** **Doctor's Signature** **Date Form Reviewed**

ADJUST CHIROPRACTIC REVIEW OF SYSTEMS (pg. 2) HR#: _____

Allergies/Autoimmune/Immunological				Dermatological				Eyes			
Seasonal Allergies	C	P	N	Mole (increased size or color)	C	P	N	Blurred/ Double Vision	C	P	N
Food Allergies	C	P	N	Skin Discoloration	C	P	N	Floaters/Flashes/Halos	C	P	N
Allergies to Medications	C	P	N	Eczema	C	P	N	Light Sensitivity	C	P	N
Latex Allergy	C	P	N	Psoriasis	C	P	N	Dryness/Irritation/Redness	C	P	N
Other Allergies	C	P	N	Tinea Versicolor	C	P	N	Eye Pain	C	P	N
Hives	C	P	N	Chronic Itching	C	P	N	Eye Discharge	C	P	N
Allergy Shots	C	P	N	Increased Skin Dryness	C	P	N	Excessive Tearing	C	P	N
Tremors	C	P	N	Rash	C	P	N	Droopy Eyelid	C	P	N
Type I Diabetes Mellitus	C	P	N	Hives	C	P	N	Conjunctivitis	C	P	N
Alopecia Areata	C	P	N	Blisters	C	P	N	Diabetic Retinopathy	C	P	N
Psoriatic Arthritis	C	P	N	Warts	C	P	N	Macular Degeneration	C	P	N
Rheumatoid Arthritis	C	P	N	Cherry angioma	C	P	N	Glaucoma	C	P	N
Multiple Sclerosis	C	P	N	Skin Cancer	C	P	N	Near/ Farsightedness	C	P	N
Systemic Lupus Erythematosus	C	P	N	Age Spots	C	P	N	Astigmatism	C	P	N
Inflammatory Bowel Disease	C	P	N	Rosacea	C	P	N	Vision Loss (R / L / B)	C	P	N
Addison's Disease	C	P	N	Flushing	C	P	N	Cataracts	C	P	N
Grave's Disease	C	P	N	Changes in Nail Beds	C	P	N	Contacts/ Glasses	C	P	N
Sjogren's Syndrome	C	P	N	Poor Wound Healing	C	P	N				
Hashimoto's Thyroiditis	C	P	N	Excessive Perspiration	C	P	N	Emotional/Mental			
Myasthenia Gravis	C	P	N	Unusual Hair Distribution	C	P	N	Anxiety/Panic Attacks	C	P	N
Autoimmune Vasculitis	C	P	N					Depression	C	P	N
Pernicious Anemia	C	P	N	Hemato/Lymphatic				Suicidal Thoughts	C	P	N
Celiac's Disease	C	P	N	Anemia	C	P	N	Suicidal Attempts	C	P	N
Polymyalgia Rheumatica	C	P	N	Sickle Cell Anemia	C	P	N	Learning Disability	C	P	N
Other: _____	C	P	N	Blood Clots/DVT	C	P	N	ADD/ADHD	C	P	N
				Varicose Veins	C	P	N	Other: _____	C	P	N
Respiratory				Clotting disorder	C	P	N				
Wheezing	C	P	N	Bruise/Bleed Easily	C	P	N	Women Only			
Asthma	C	P	N	Blood Transfusion(s)	C	P	N	Heavy/Missed/Painful Cycle	C	P	N
Bronchitis	C	P	N	HIV or HIV exposure	C	P	N	PMS	C	P	N
Pneumonia	C	P	N	Leukemia	C	P	N	Abnormal Vaginal Discharge	C	P	N
Shortness of Breath	C	P	N	Multiple Myeloma	C	P	N	Polycystic Ovarian Syndrome	C	P	N
Chronic cough	C	P	N	Swollen Lymph Nodes	C	P	N	Endometriosis	C	P	N
Coughing up blood	C	P	N	Lymphoma	C	P	N	Pregnancy(ies) #: _____	C	P	N
Excessive Sputum	C	P	N	Lymphedema	C	P	N	Miscarriage(s) #: _____	C	P	N
Excessive Snoring	C	P	N	Lymphangitis	C	P	N	Hot Flashes	C	P	N
Sleep Apnea	C	P	N	Tonsillitis	C	P	N	Menopause Challenges	C	P	N
Emphysema	C	P	N					Cervical/Uterine Cancer	C	P	N
COPD	C	P	N	Renal/Genitourinary				Breast Cancer	C	P	N
Lung Cancer	C	P	N	Difficulty/Burning Urination	C	P	N	Sexually Transmitted Disease	C	P	N
Pulmonary Fibrosis	C	P	N	Urinary Incontinence	C	P	N				
Pulmonary Hypertension	C	P	N	Urinary Urgency	C	P	N	Men Only			
Cystic Fibrosis	C	P	N	Blood in Urine	C	P	N	Low Testosterone	C	P	N
Bronchiectasis	C	P	N	Inability to Empty Bladder	C	P	N	Benign Prostatic Hyperplasia	C	P	N
Pleural Effusion	C	P	N	Wake at Night to Urinate	C	P	N	Prostate Cancer	C	P	N
Mesothelioma	C	P	N	Urinary Tract Infection	C	P	N	Erectile Dysfunction	C	P	N
Tuberculosis	C	P	N	Bladder/Kidney Infection	C	P	N	Testicular Cancer	C	P	N
				Kidney Stones	C	P	N	Testicular Pain/Swelling	C	P	N
				Kidney Cancer	C	P	N	Burning Discharge	C	P	N
					C	P	N	Sexually Transmitted Disease	C	P	N

If other conditions please list here: _____

_____

_____ _____-_____-_____ _____ _____-_____-_____

Patient's Signature Date Completed Doctor's Signature Date Form Completed

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache				Neck				Low Back		
No pain	0	1	(2)	3	4	(5)	6	7	(8)	9	10	worst possible pain

---

1 – What is your pain RIGHT NOW?

No pain	0	1	2	3	4	5	6	7	8	9	10	worst possible pain

2 – What is your TYPICAL or AVERAGE pain?

No pain	0	1	2	3	4	5	6	7	8	9	10	worst possible pain

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain	0	1	2	3	4	5	6	7	8	9	10	worst possible pain

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain	0	1	2	3	4	5	6	7	8	9	10	worst possible pain

OTHER COMMENTS:

_____

_____

_____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

PATIENT'S NAME: _____ HR#: _____ DATE: _____

ADJUST CHIROPRACTIC

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Adjust Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
_____	_____	____/____/____
Witness Name (print)	Witness Signature	Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
_____	_____	____/____/____
Witness Name (print)	Witness Signature	Date

ADJUST CHIROPRACTIC
DR. ANNA STORY
1258 WASHINGTON RD. THOMSON, GA 30824
706.597.0059 706.597.9100 ADJUSTCHIRO.NET

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE PERSONAL INJURY, WORK COMP, ERISA, AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND / OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, any and all medical benefits and/or any insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of all medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Signature: _____ Date: _____

Print Name: _____

For Office Use Only
Signed form received by: _____

Effective Date: _____ **Notice of Privacy Practices**

ADJUST CHIROPRACTIC
1258 WASHINGTON RD THOMSON, GA 30824
ADJUSTCHIRO.NET

DR. ANNA STORY
706.597.0059
ADJUSTCHIRO.THOMSON.AJ@GMAIL.COM

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff. **Keep this page for your records.**

YOUR RIGHTS:

1. To inspect or obtain a copy of your records within 15 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address).
4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
5. To receive an accounting of disclosures (those with whom we've shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

USES AND DISCLOSURES:

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient's death.
9. For workers' compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency – in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

COMPLAINT:

f you wish to make a complaint about how we handle your health information, please contact our privacy official using the information noted above. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

U.S. Dept. of Health and Human Services, Office of Civil Rights
200 Independence Avenue, SW, Washington DC 20201
877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued ...

Please complete the following where indicated and return to our front desk staff.

Patient initials: _____ - **retaining *page 1 of 2***

I hereby acknowledge I have read and received a copy of Adjust Chiropractic Privacy Practices Notice.

I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.

I am aware an extended detail version of this "Notice" is available to me upon request.

At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

_____ Parent or guardian of minor patient

_____ Guardian or conservator of an incompetent patient

_____ Beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only

Signed form received by: _____

Reason acknowledgment not obtained: _____

Efforts to obtain: _____

PATIENT'S NAME: _____ HR#: _____ DATE: _____

PATIENT'S NAME: _____ HR#: _____ DATE: _____

Adjust Chiropractic-HIPAA Personal Health Information Release

I, _____, hereby authorize Adjust Chiropractic to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- O Spouse Name: _____
- O Significant Other Name: _____
- O Parent/Legal Guardian Name: _____
- O Child(ren) Name(s): _____
- O Any Specified Person Name: _____
- O Information is not to be discussed with or released to anyone.

Restrictions:

- O No Restrictions
- O Only discuss my appointment time with the above-named individual(s).
- O Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- O Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call O my home O my work O my cell phone
Phone Number: _____ - _____ - _____

If unable to reach me:

- O you may leave a detailed message
- O please leave a message asking me to return your call
- O _____

I understand I may terminate this consent at any time by giving written notice to Adjust Chiropractic. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: _____ Date: _____

ADJUST CHIROPRACTIC

Office Financial Policy

We are pleased you chose our office for your care. Please read thoroughly and sign.

1. We are glad to file your insurance if we are providers for your plan. You will be responsible for any co-payment at the time of each visit. In order to file your insurance, you must present the office with a photo ID and copy of your insurance card.
2. If your insurance denies payment on your account, you will be asked to pay by check, cash or credit card. If you do not pay in a timely fashion, you will be responsible for any and all accrued charges.
3. You also have the option to be a cash pay patient. Payment in full is due at the time of the appointment.
4. Due to the high demand for appointments, you will be asked to pay a one-time deposit in the amount of $25.00 to guarantee your place on the schedule. This charge will be applied to your initial exam fee. This deposit is non-refundable if you do not make your appointment.
5. We want to make it as convenient as we can for you, as everyone prefers different forms of payments. We do accept cash, checks, credit card, debit card and care credit as forms of payment. If a check is returned you will be charged a fee of $30 in addition to the initial amount of the check, and will be a CASH ONLY patient thereafter.
6. Should you need to cancel or reschedule your appointment we require a **24-hour notice**. If a 24-hour notice is **not** given you will be subject to a $20 non-refundable fee.
7. Should you need paperwork or a copy of your x-rays there will be a fee of $25.00. You will need to sign a release and the request will be processed within 72 business hours of your initial request for documents.
8. If you receive a bill and have any questions or concerns you can contact our billing department at 833-408-0071.

If you have any questions regarding our policy, please ask PRIOR to being seen.

Patient Signature:_____ **Date:** _____

Printed Name: _____ **Witness:** _____