PATIENT IDENTIFICATION

NAME: _____ **Today's Date:** _____

MALE ( ) FEMALE ( )

D.O.B: _____ **AGE:** _____ **Referred By:** _____

SSN: _____ - _____ - _____ **PCP:** _____

Occupation: _____

ADDRESS: _____ **Telephone: (H)** _____

_____ **(C)** _____

_____ **(W)** _____

Ok to call there? Y / N

May we contact you via e-mail for appointment reminders or office closures? Y / N

E-mail Address: _____

In case of an emergency, who should we contact?

Name and Relation: _____

Telephone Number: _____

Name of parent if patient is a minor: _____

Will your treatments be covered under:

Workers' Compensation ( )

Motor Vehicle Accident ( )

Primary Health Insurance ( )

Cash Plan ( )

Please give all information and insurance card to the front desk

CASE HISTORY

Complaint: _____

_____

When did it begin? _____

Any accidents or trauma involved? If yes, please explain: _____

_____

Type of pain: _____

What aggravates this condition? _____

What makes it feel better? (Heat, ice, rest): _____

Have you experienced this condition before? If yes, please explain: _____

_____

Any prior treatment? If yes, please explain: _____

_____

Has this condition affected your sleeping pattern? If yes, please explain: _____

_____

Any abnormal weight change or change is appetite? If yes, please explain: _____

_____

Any changes in bowel or bladder function? If yes, please explain: _____

_____

Are you symptoms worsened by coughing? _____ Sneezing? _____

Have you had any testing? If yes, please explain: _____

_____

Have you had any surgeries? If yes, when? _____

_____

Fractures? If yes, when? _____

_____

Any Comments or Current Meds: _____

_____

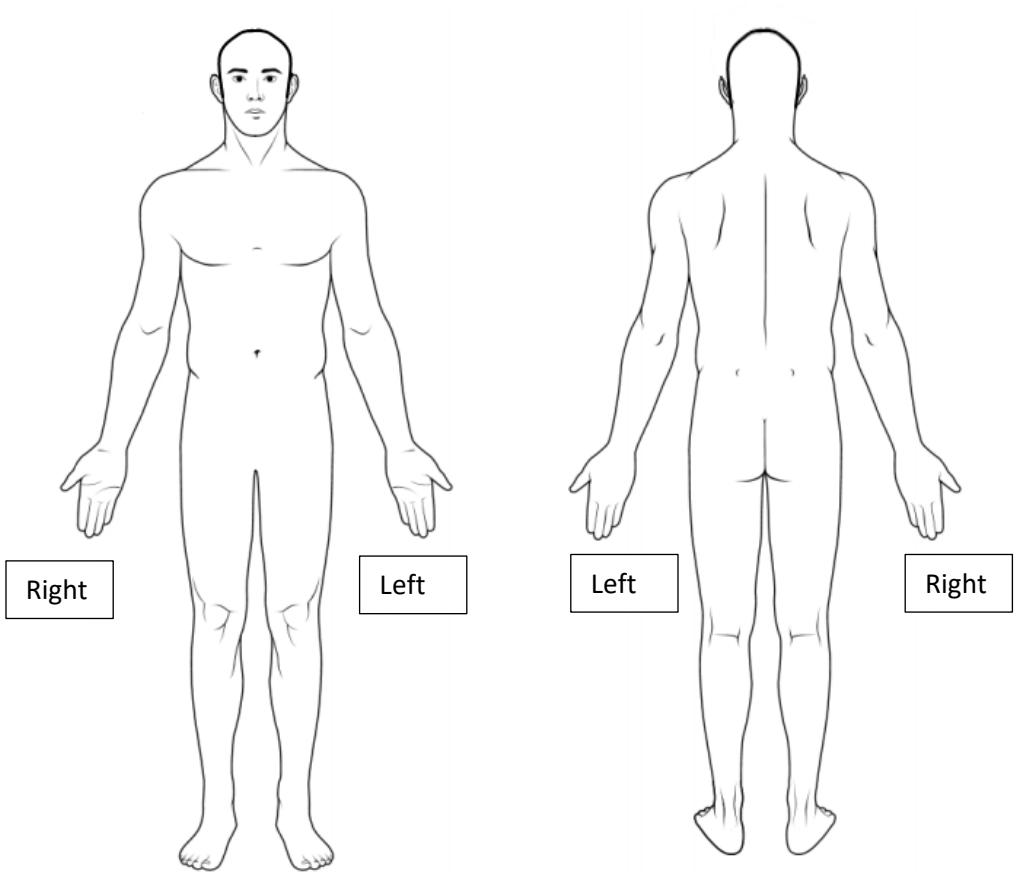
_____

DX: _____

PAIN CHART

Patient Name: _____ DOB: _____

Please mark on the chart where you feel your pain.



Please rate your pain using a 0 – 10 scale. 0 being no pain at all. 10 being severe pain.

Pain at best: ____ / 10

Pain on average: ____ / 10

Pain at worst: ____ / 10

ASSIGNMENT OF BENEFITS

I hereby instruct my insurance company to pay by check made out and mailed directly to this clinic the professional and/or medical expense benefits allowed, which are otherwise payable to me under my current insurance policy, as payment to ward the total charges for services rendered by this clinic. If payment for services rendered by this clinic is made directly to me from my insurance company, I hereby guarantee to present these monies in a timely fashion. A photocopy of this agreement shall be as valid as the original.

PATIENT INTITALS: _____ DATE: _____

RELEASE OF INFORMATION

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, attorney, or health care provider involved in my case. I hereby release this clinic of any consequences thereof.

PATIENT INTITALS: _____ DATE: _____

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-insurance, co-payment, and any services rejected by my insurance company.

PATIENT INTITALS: _____ DATE: _____

APPOINTMENT REMINDERS

I understand that this clinic may at times use my personal contact information to remind me of scheduled appointments, information about treatment alternatives, and other health related circumstances. If this contact is made via telephone and I am not available, a message will be left for me. By signing this form I authorize this clinic to contact me with these reminders and information. Refusal of the authorization will not affect my treatment. I am entitles to review and limit the contact information to be used.

PATIENT INTITALS: _____ DATE: _____

PATIENT SIGNATURE: _____ DATE: _____

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that mat identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, 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, to pay your health care bills, to support the operation of the physician's practice, and any other required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manager your health care and any related services. This included the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provided care to you. For example, your PHI may be provided to a physician to whom have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to your and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights

Following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records, psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHU that is subject to law that prohibits access to PHI.

Your have the right to request a restriction of your PHI. This means you may ask us not to use or disclosure any part of your PHI for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your PHI 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 to restriction to apply.

Your physician is not required to agree to a restriction that your may request. If physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will *NOT* be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of the notice from us, upon request, even if you have agreed to accept this notice alternatively. I.E., electronically.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we many 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 PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to use of 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**.

This notice was publish and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____

Date: _____