WELCOME TO ADVANCED HEALTH CHIROPRACTIC

PATIENT REGISTRATION

Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F S.S. Number: _____-_____-_____
Address: _____ /_____ /_____ /_____
Street City State Zip Code
Phone: (Home)_____ (Cell)_____ (Work)_____ Ext._____
Email: _____
Occupation: _____ Employer: _____
Emergency Contact: (Name) _____ (Phone Number) _____
Who may we thank for referring you to our office? _____

INSURANCE INFORMATION

Insured's Name: _____ Insured's Date of Birth: _____ Phone: _____
Relationship to Insured: ☐ Self ☐ Spouse ☐ Child
Spouse's Name: _____ Spouse's Employer: _____
Insurance Company: _____ Insurance ID: _____
Spouse's Insurance Company: _____ Spouse's S.S Number: _____-_____-_____

ACCIDENT INFORMATION (If Applicable)

Are your present problems due to an injury? ☐ Yes ☐ No If yes, how? ☐ On the Job ☐ Auto Accident ☐ Other _____
Has the accident been reported? ☐ Yes ☐ No If yes, to whom? ☐ Employer ☐ Auto Carrier ☐ Other _____
Are you now or have you ever been disabled (service or work)? ☐ Yes ☐ No When?_____ Why?_____
Have you retained an attorney? ☐ Yes ☐ No Name and Address: _____

FAMILY HISTORY

	Heart	Kidney	Cancer	Diabetes
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Brother, # of	☐	☐	☐	☐
Sister, # of	☐	☐	☐	☐

OTHER: _____

OPERATIONS AND PROCEDURES

(Date)		(Date)		(Date)	
_____	Tubes in Ears	_____	Sinus	_____	Tonsillectomy
_____	Appendectomy	_____	Hernia	_____	Female Organs
_____	Gall Bladder	_____	Thyroid	_____	Rectal Surgery
_____	Back Operation	_____	Stomach	_____	Other:_____

☐ I have never had any operations/surgeries

ASSIGNMENT, RELEASE AND CONSENT

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment.

I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for non-covered services. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt.

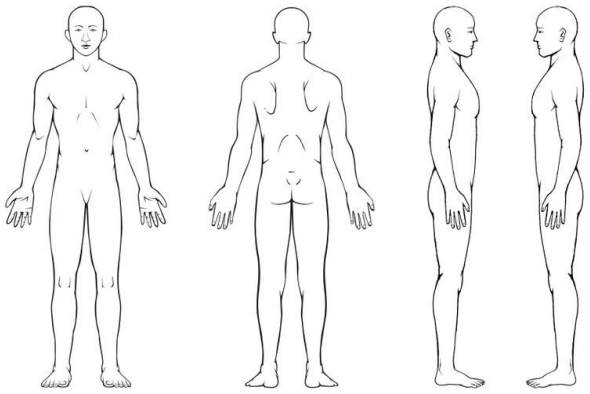
I hereby give permission to the doctor to administer treatment and perform such general procedures, as he may deem necessary in the diagnosis and/or treatment of my condition. In rare cases, underlying physical defects, defects, deformities or pathologies may render the patient susceptible to injury.

I have read, and understand the foregoing. Signature:_____

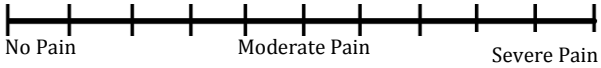
CONDITION

1. Area of Complaint: _____
   When did your symptoms start? _____
   How did your symptoms begin? _____

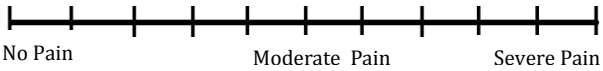
Mark or shade in where you have pain or other symptoms on the drawings to the right:



2. 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)
3. What describes the nature of your symptoms? (Check all that apply)
   - ☐ Sharp ☐ Shooting
   - ☐ Dull Ache ☐ Burning
   - ☐ Numb ☐ Tingling
   - ☐ Other: _____
4. How are your symptoms changing?
   ☐ Getting Better ☐ Not Changing ☐ Getting Worse
5. Circle the average intensity of your symptoms:



6. Circle in your symptoms at their worst:



7. Who have you seen for your symptoms?
   ☐ No One ☐ Medical Doctor ☐ Physical Therapist ☐ Other Chiropractor
   ☐ Other: _____
8. Have you had similar symptoms in the past? ☐ Yes ☐ No If so, when? _____
9. What makes your symptoms feel better? _____
10. What makes your symptoms feel worse? _____
11. What activity/activities does this problem prevent you from doing, either partially of totally, that you would really like to be doing again? _____
    _____
12. Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
13. Do you suffer from any conditions other than that which you are now consulting us? _____
14. Have you had any fevers lately? _____ If so, when? _____
15. Have you had any unusual shortness of breath? _____If so, when? _____

Most patients that come to our office have one of two objectives in mind concerning their healthcare. Some patients come for symptomatic relief of pain or discomfort (relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (corrective care). Dr. George will weigh your needs and desires when recommending your treatment program.

☐ Relief Care ☐ Corrective Care ☐ Check here if you want Dr. George to select the type of care appropriate for your condition

_____ DO NOT WRITE BELOW THIS LINE _____
_____
_____
_____
_____
_____
_____

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine and surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, and physical and spinal conditions. It is important to understand what to expect from chiropractic health care.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complex (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express and opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illness, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnosis and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to word with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule of efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy.

I have read, and understand the foregoing. Signature: _____

Date: _____

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitation of the disclosure of your health information and your right as a patient. It is located on the last page of this packet. If you have any questions or concerns regarding the use or dissemination of your personal health information, we will be happy to address them.

I acknowledge that I have received a copy of Advanced Health Chiropractic's Notice of Privacy Practices for Protected Health Information.

Signature: _____ Date: _____

APPOINTMENT REMINDER AND HEALTH CONCERN

Your chiropractor and members of the practice 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 related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine.

You may restrict individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. In addition, if we are required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us this authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as of today's date. This authorization will expire seven years after the date on which you last received services from us.

Do you wish to provide us authorization to use or disclose my health information in the manner described above?

☐ Yes ☐ No

Signature: _____ Date: _____

NON-COVERED SERVICES NOTICE

When Dr. George orders x-rays to be taken we bill your insurance for the x-ray reread; if it not covered by your insurance a $15 x-ray reread charge will be billed to you.

When Dr. George performs a re-exam we bill your insurance for the re-exam; if it is not covered by your insurance a $25 re-exam charge will be billed to you.

The same will apply if you are a Time of Service (TOS) patient.

I have read, and understand the foregoing. Signature: _____

ADVANCED HEALTH CHIROPRACTIC

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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

USES AND DISCLOSURES

Here are some examples of how we might need to use or disclose your health care information:

1. Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or to your employer if they are potentially responsible for the payment of your services.
3. Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about your treatment alternatives, or other health related information that may be of interest to you (164.520(b)(1)(iii)(A)). If you are not at home to receive an appointment reminder, a message will be left on your answering machine. We may also send appointment reminder postcards to your home address.
4. Your chiropractor and members of the staff may need to use your health information, examination and treatment records, and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

OUR PRIVACY PLEDGE

We have and always will respect your privacy. Other than the uses and disclosures listed above, *we will not sell or provide any of your health information to any outside marketing organization*.

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. We are permitted to use or disclose your health information if we provide health care services to you based on the orders of another health care provider.
2. We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3. We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4. We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
5. We are permitted to use or disclose your health information if there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples, any other use or disclosure of your health information will only be made with your written authorization.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your authorization to us at any time. However, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization (164.508(b)(5)(i)).
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

If you wish to revoke your authorization, please write us at:

Advanced Health Chiropractic
66 Main Street
Lakeville, MA 02347

YOUR RIGHT TO LIMITED USES OR DISCLOSURES

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want to us to disclose your health information, please let us know. In writing, notify us what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

YOUR RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATION REGARDING YOUR HEALTH INFORMATION

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in another form. To help us respond to your needs, please make any requests in writing.

YOUR RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

YOUR RIGHT TO AMMEND YOUR HEALTH INFORMATION

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our file. We require your request to be in writing and for you to give us a reason to support the change you are requesting us to make.

YOUR RIGHT TO RECEIVE AN ACCOUNTING OF THE DISCLOSURE WE HAVE MADE OF YOUR RECORDS

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

1. Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
2. Those disclosures made to you.
3. Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
4. Those disclosures for national security or intelligence purposes.
5. Those disclosures made to correctional officers or law enforcement officers.
6. Those disclosures that were made prior to the effective date of the HIPPA privacy law.

We will provide the first accounting within any 12 month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

YOUR RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

If you have agreed to receive privacy notices by e-main, you may request a paper copy of this notice at any time.

OUR DUTIES

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.
We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all your health information in our files.

RE-DISCLOSURE

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

YOUR RIGHT TO COMPLAIN

You may complain to us or to the secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to the address listed below.

TO CONTACT US

If you would like further information about our privacy policies and practices or a copy of this document in a larger font please contact:

Advanced Health Chiropractic
66 Main Street
Lakeville, MA 02347
508-947-0747

THIS NOTICE IS EFFECTIVE AS OF JANUARY 1, 2018. THIS NOTICE WILL EXPIRE SEVEN YEARS AFTER THE DATE UPON WHICH THE RECORD WAS CREATED.