1. PATIENT INFORMATION

Date_____

SS/HIC/Patient ID #_____

Patient
Name_____
Last Name

_____
First Name Middle Initial

Address_____

City_____

State_____ ZIP_____

E-mail_____

Sex M_____ F_____ Age_____

Birthdate_____

____Married ____Widowed ____Single ____Minor

____Separated _____Divorced Partnered for __yrs

Patient Employer/School_____

Occupation_____

Employer/School Address_____
_____

Employer/School Phone ( ) _____

Spouse's Name_____

Birthdate_____

SS#_____

Spouse's Employer_____

Whom may we thank for referring you?
_____

2. INSURANCE INFORMATION

Who is responsible for this account?
_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance?

Yes___ No_

Subscribe's Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group#_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Dr._____
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services. This consent will end when I choose to no longer receive services from Atlantic Chiropractic, LLC.

_____
Signature of Patient, Parent, Guardian or Personal Rep

_____
Please print name of Patient, Parent, Guardian or Personal Rep.

_____ _____
Date Relationship to Patient

3. PHONE NUMBERS

Cell Phone ( )_____

Home Phone ( )_____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Home Phone ( )_____

Work Phone ( )_____

4. ACCIDENT INFORMATION

Is condition due to an accident? _____Yes ____No

Date of Accident_____

Type of accident ____Auto ____Work ____Home

_____Other

To whom have you made a report of your accident?

___Auto Insurance ___Employer ___Worker Comp

___Other

_____

Attorney Name (if applicable)

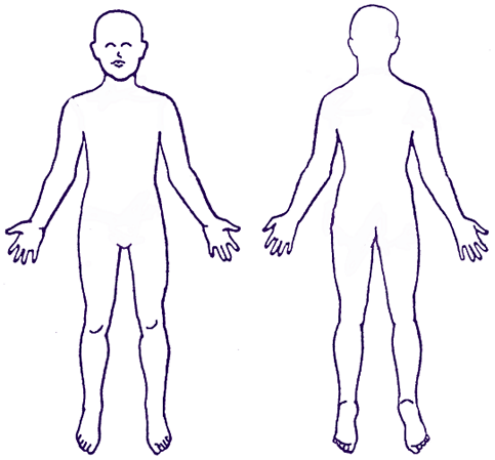
5. PATIENT CONDITION

Reason for Visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse? _____Yes _____No ____Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1(least pain) to 10 (severe pain)_____

Type of pain: ___Sharp ___Dull ___Throbbing ___Numbness

___Aching ___Shooting ___Burning ___Tingling ___Cramps

___Stiffness ___Swelling ___Other

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your ___Work ___Sleep ___Daily Routine ____Recreation

Activities or movements that are painful to perform ___Sitting __Standing __Walking __Bending __Lying down.

6. HEALTH HISTORY

What treatment have you already received for your condition?

___Medications ___Surgery ___Physical Therapy ___Chiropractic Services ___None

Other_____

Name and address of other doctor(s) who have treated you for your condition_____

_____.

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	___Yes ___No	Heart Disease	___Yes ___No	Rheumatoid Arthritis	__Yes ___No
Alcoholism	___Yes ___No	Hepatitis	___Yes ___No		
Allergy Shots	___Yes ___No	Hernia	___Yes ___No	Rheumatic Fever	___Yes ___No
Anemia	___Yes ___No	Herniated Disk	___Yes ___No		
Anorexia	___Yes ___No	Herpes	___Yes ___No	Scarlet Fever	___Yes ___No
Appendicitis	___Yes ___No	High Blood Pressure	___Yes ___No	Sexually Transmitted Disease	___Yes ___No
Arthritis	___Yes ___No				
Asthma	___Yes ___No	High Cholesterol	___Yes ___No		
Bleeding Disorders	___Yes ___No	Kidney Disease	___Yes ___No	Stroke	___Yes ___No
		Liver Disease	___Yes ___No	Suicide Attempt	___Yes ___No
Breast Lump	___Yes ___No	Measles	___Yes ___No		
Bulimia	___Yes ___No	Migraine		Thyroid Problems	___Yes ___No
Bronchitis	___Yes ___No	Headaches	___Yes ___No		
Cancer	___Yes ___No	Miscarriage	___Yes ___No	Tonsillitis	___Yes ___No
Cataracts	___Yes ___No	Mononucleosis	___Yes ___No	Tuberculosis	___Yes ___No
Chemical Dependency	___Yes ___No	Multiple Sclerosis	___Yes ___No	Tumors/ Growths	___Yes ___No
		Mumps	___Yes ___No		
Chicken Pox	___Yes ___No	Osteoporosis	___Yes ___No	Typhoid Fever	___Yes ___No
Diabetes	___Yes ___No	Pacemaker	___Yes ___No	Ulcers	___Yes ___No
Emphysema	___Yes ___No	Parkinson's Disease	___Yes ___No	Vaginal Infections	___Yes ___No
Epilepsy	___Yes ___No	Pinched Nerve	___Yes ___No		
Fractures	___Yes ___No	Pneumonia	___Yes ___No	Whooping Cough	___Yes __No
Glaucoma	___Yes ___No	Polio	___Yes ___No		
Goiter	___Yes ___No	Prostate Problem	___Yes ___No	Other	
Gonorrhea	___Yes ___No	Prosthesis	___Yes ___No	_____	
Gout	___Yes ___No	Psychiatric Care	___Yes ___No	_____	

6. HEALTH HISTORY, CONTINUED

EXERCISE	WORK ACTIVITY	HABITS
__None	__Sitting	__Smoking Packs/Day _____ Did you ever smoke? Y/N
__Moderate	__Standing	__Alcohol Drinks/Week_____
__Daily	__Light Labor	__Coffee/Caffeine Cups/Day _____
__Heavy	__Heavy Labor	__High Stress Level Reason _____

Are you Pregnant? __Yes No__ Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Has any immediate family member had any family history of diseases or disorders?

Relationship	Circle One	Disease or Disorder
Mother	Y/N	
Father	Y/N	
Sister	Y/N	
Brother	Y/N	
Son	Y/N	
Daughter	Y/N	

7. MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

ATLANTIC CHIROPRACTIC OFFICE POLICY

FINANCIAL OBLIGATION

I (the patient) agree that I am financially responsible for payment of all amounts of services provided by Atlantic Chiropractic. I am responsible to pay for my services regardless of insurance coverage or other agreements between Atlantic Chiropractic and my insurer, or if prohibited by state or federal laws or regulations. If my insurance plan is a Health Maintenance Organization (HMO) or Medicare, I understand that I am financially responsible for non covered services or deductibles, co-pays, or co-insurances as defined in my policy or plan. If the amount I am responsible for is not paid in full within thirty (30) days of receipt of the bill, I agree to pay interest at the rate of 18% Per Annum, billed and compiled monthly at 1.5%. I further agree to pay collection costs up to 50% of the principal debit and the responsible attorney fees and expenses. I give consent for any collection agency to contact me via the information that I have give Atlantic Chiropractic, including, but not limited to, my address, home phone number, and/or cell phone number. I agree to waive venue. This includes patients account balances, and the collection of other expenses related to the patient account balance such as interest, service fees, court costs, and attorney fees. Credit terms are liberally awarded to active patients and strictly enforced with inactive patients.

I understand that Atlantic Chiropractic will provide routine and reasonable insurance claims processing to most carriers as a courtesy for me. In return, they expect cooperation from me, if necessary, to help collect any amounts due.

I understand that Atlantic Chiropractic reserves the right to refuse this courtesy or withdraw it at any time. I understand that Atlantic Chiropractic charges for extraordinary processing, such as reports, copies, or records, etc.

It is understood and agreed that any amounts paid to Atlantic Chiropractic for x-rays are for examination only, the negatives are property of Atlantic Chiropractic, and will remain as part of the permanent patients file.

I understand that Atlantic Chiropractic will not be held responsible for any pre-existing medically diagnosed conditions.

CONSENT TO BILL INSURANCE

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. Furthermore, I understand that Atlantic Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized is paid directly to Atlantic Chiropractic. I also understand that this amount will be credited directly to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me, and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release Atlantic Chiropractic and its employees to administer treatment, physical examination, x-rays studies, laboratory procedures, chiropractic care or any clinic services it deems necessary in my case. I furthermore authorize Atlantic Chiropractic to disclose all or any part of my patient records to any person or corporation which is or may be liable under contract to Atlantic Chiropractic or to me or to a family member or employer of me for all or part of the Atlantic Chiropractic charges, including and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or my employer.

TIMELY APPOINTMENTS

I understand that when I schedule and appointment I am closing off that appointment to other potential patients. Therefore, in order for Atlantic Chiropractic to provide timely service to all patients, ***I understand that Atlantic Chiropractic requires that if I cannot make it to my appointment and have to cancel for any reason, I will give a 24-hour minimum notice. I agree that I am subject to a $50 office visit fee for failure to provide such notice.*** Furthermore, I understand that third-payers may not cover this fee.

_____ _____

Patient, parent if minor child, or guardian
(If patient is unable to sign. Representative name and relationship)

Date

Patient Name:_____

The material risk inherent in Chiropractic adjustments
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocation, muscle strain, cervical myelopathy, costovertebral strains, separation, and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contradictions to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risk occurring
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check during the taking of the history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustment. The other complications are also generally described as rare.

The availability and nature of other treatment options
Other treatment options for your condition may include:
***** Self-administered, over-the-counter analgesics and rest
***** Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
***** Hospitalization
***** Surgery
If you choose to use one of the above noted “other treatment” options, you should be aware that there are risk and benefits of such options and you may wish to discuss these with your primary medical physician.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the chiropractor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risk, I hereby give my consent to that treatment.

_____ _____

Patient’s Name **Date** **Doctor’s Name** **Date**

_____ _____

Signature **Signature**

_____

Signature of Parent or Guardian (if a minor)

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

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. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

•Treat you

We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

•Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

•Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reported suspected abuse, neglect, or domestic violence; and, preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will 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.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you for workers' compensation claims for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share health information about you in a response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective September 23, 2013 Signature: _____ Date: _____