# WELCOME TO OUR OFFICE

PATIENT FIRST NAME__________________LAST________________________MIDDLE____________

STREET ADDRESS______________________________________________________________________

CITY____________________________STATE________________ZIP CODE______________________

HOME PHONE #____________________________WORK PHONE #______________________________

CELL PHONE #____________________________E-MAIL_____________________________________

MARITAL STATUS: M S D W DATE OF BIRTH____/_____/_____ AGE_______________

SOCIAL SECURITY #__________________EMPLOYER________________________________________

OCCUPATION_______________________NUMBER/AGES OF CHILDREN___________________________

EMERGENCY CONTACT _________________________________PHONE #______________________

RELATIONSHIP TO EMERGENCY CONTACT? _________________________________________________

WHOM MAY WE THANK FOR REFERRING YOU? ______________________________________________

DATE OF LAST PHYSICAL EXAM? _______________DO YOU THINK YOU ARE PREGNANT?___________

PURPOSE OF THIS APPOINTMENT_________________________________________________________

NAME OF OTHER DOCTORS SEEN FOR THIS CONDITION? _____________________________________

HAVE YOU BEEN TREATED FOR ANY OTHER HEALTH CONDITIONS IN THE PAST YEAR?

DESCRIBE____________________________________________________________________________

HAVE YOU EVER SUFFERED FROM?

| | | | |
|---|---|---|---|
| HEART TROUBLE | ____________ | DIGESTIVE DISORDERS | ____________ |
| DIZZINESS | ____________ | NEURITIS | ____________ |
| ASTHMA | ____________ | BACKACHE | ____________ |
| TUBERCULOSIS | ____________ | NERVOUSNESS | ____________ |
| ARTHRITIS | ____________ | ANEMIA | ____________ |
| HEADACHES | ____________ | RHEUMATIC FEVER | ____________ |
| CANCER | ____________ | ALLERGIES | ____________ |

PRIMARY INSURANCE TO BE BILLED______________________________________________
INSURED NAME ______________________________ INSURED DATE OF BIRTH_____/_____/_____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT POLICIES ARE AN ARRANGEMENT BETWEEN THE INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT ATLAS CHIROPRACTIC WILL PREPARE ANY NECESSARY FORMS TO ASSIST ME IN COLLECTING FROM MY PRIMARY INSURANCE CARRIER AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO ATLAS CHIROPRACTIC WILL BE CREDITED TO MY ACCOUNT ON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE. **WE DO NOT BILL SECONDARY INSURANCE CARRIERS.**

**PATIENT'S SIGNATURE**______________________________**DATED**____________________

**GUARDIAN SIGNATURE**______________________________**DATED**____________________

*ATLAS CHIROPRACTIC, PLLC*
*CLARE M. MCDANIEL, D.C.     BRADLEY A. FRIEND, D.C.*
*1137 VANVOORHIS ROAD, SUITE 3*
*MORGANTOWN WV 26505*
*(304) 598-3000*

## *ASSIGNMENT*

*I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic.*

*A photocopy of this assignment shall be considered as effective and valid as the original.*

______________________ __________________
*Patient signature*     *Date*

## *RELEASE OF INFORMATION*

*I authorize any doctor, hospital, employer, to other person to whom a signed or photo-copy of this authorization is delivered to furnish any information, reports or copies of records which may be requested by Atlas Chiropractic or its representatives. I also permit Atlas Chiropractic to release any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case; and hereby release this clinic of any consequence thereof.*

______________________ __________________
*Patient signature*     *Date*

______________________ _____/_____/_____
*Print name*     *Date of Birth*

## *FINANCIAL RESPONSIBILITY*

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

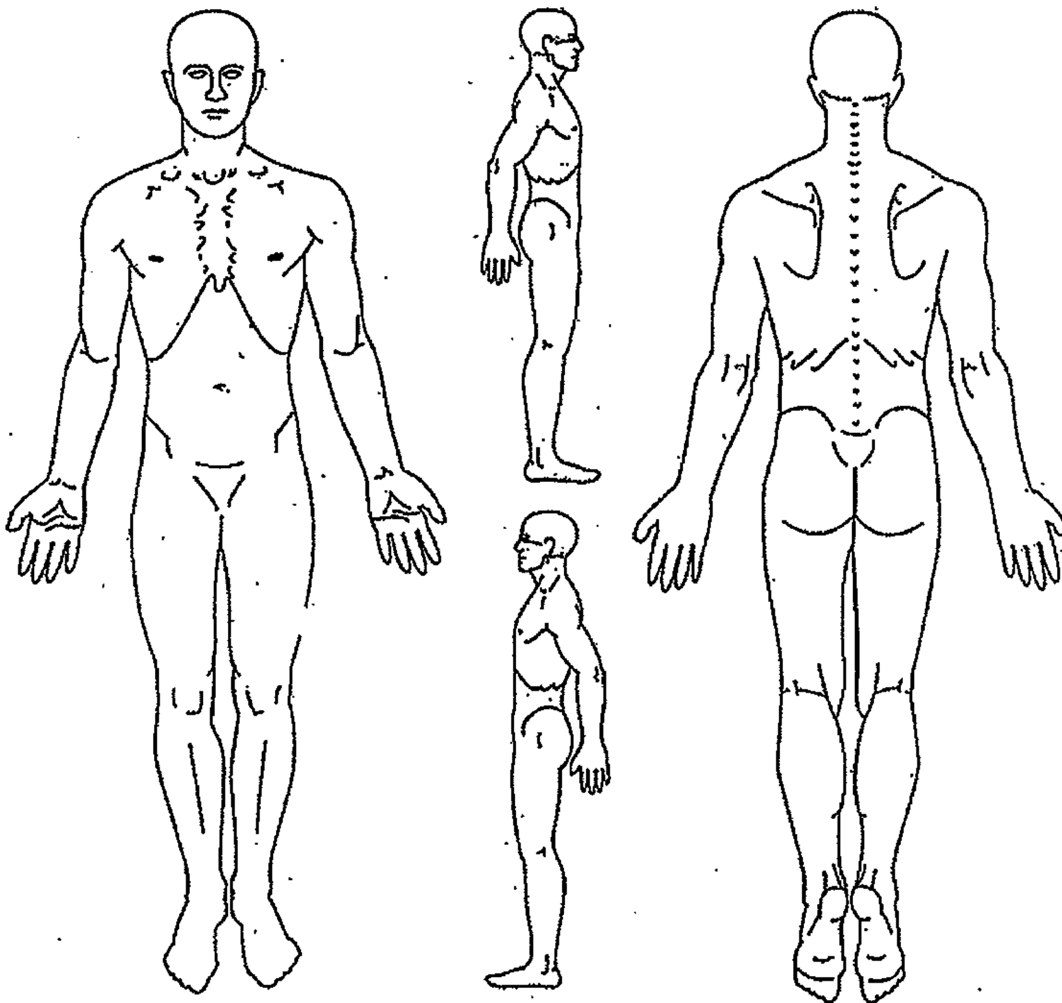
______________________ __________________
*Patient signature*     *Date*

Patient Name(Print)______________________________ Date______________

Patient ID #______________

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

| | |
|---|---|
| **D** = Dull | **S** = Stabbing/Cutting |
| **B** = Burning | **T** = Tingling (Pins & Needles) |
| **N** = Numb | **C** = Cramping |



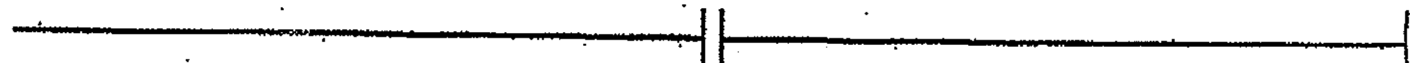
On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:** | Rate your pain at its **best** in the past week:

No Pain | Unbearable Pain | No Pain | Unbearable Pain

Rate your **average** pain in the past week: | Rate your **worst** pain in the past week:

No Pain | Unbearable Pain | No Pain | Unbearable Pain



## "GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTIONAL TEST"

**Patient's Name**_________________________ **Date**____________ **Age**____________ **Sex**______

**Instructions: Please circle the correct response. Sign and date when completed.**

**HISTORICAL INFORMATION:**

Have you ever been diagnosed or told you had any of the following?

| | | | |
|---|---|---|---|
| 1. | High Blood pressure (hypertension)? | YES | NO |
| 2. | Hardening of the arteries (arteriosclerosis)? | YES | NO |
| 3. | Diabetes? | YES | NO |
| 4. | Heart or blood vessel diseases? | YES | NO |
| 5. | Bone spurs on the neck bones (cervical spondylosis)? | YES | NO |
| 6. | Whiplash injury (flexion/extension injury) (cervical sprain)? | YES | NO |
| 7. | Have any of your relatives ever suffered from a stroke? | YES | NO |
| 8. | Where you ever a smoker? From________To__________ | YES | NO |
| 9. | Do you take any medication on a regular basis? Please list______________________________ ______________________________ | YES | NO |
| 10. | (WOMEN ONLY) Have you ever taken oral contraceptives? From__________________TO___________________ | YES | NO |

Have you had any of the following, even short, temporary attacks, in the last year?

| | | | |
|---|---|---|---|
| 11. | Blurred vision? | YES | NO |
| 12. | Double vision? | YES | NO |
| 13. | Diminished or partial loss of vision in one or both eyes? | YES | NO |
| 14. | Complete loss of vision in one or both eyes? | YES | NO |
| 15. | Ringing, buzzing or any noise in the ear(s)? | YES | NO |
| 16. | Hearing loss in one or both ears? | YES | NO |
| 17. | Slurred speech or other speech problems? | YES | NO |
| 18. | Difficulty swallowing? | YES | NO |
| 19. | Dizziness? | YES | NO |
| 20. | Temporary lack of understanding? | YES | NO |
| 21. | Loss of consciousness, every momentary blackouts? | YES | NO |
| 22. | Numbness or loss of sensation in the face, fingers, hand, arms, legs or other parts of your body? | YES | NO |
| 23. | Any other abnormal sensations in any part of your body? | YES | NO |
| 24. | Weakness, clumsiness or loss of strength in the face, fingers, hands arms, or legs? | YES | NO |
| 25. | Sudden collapse without loss of consciousness? | YES | NO |

______________________________ ______________________________

Patient's Signature Date

## ATLAS CHIROPRACTIC SPINAL CARE PRIVACY PRACTICE
## EFFECTIVE APRIL 01, 2003

**This notice describes how your health information may be used and disclosed and how you can obtain this information. Please review it carefully.**

**Protected Health Information (PHI)** means any patient information relating to treatment, diagnosis, or payment that identifies a person.

### Uses and Disclosures of Protected Health Information

We use PHI when we within our organization share, examine, or analyze a patient's chiropractic information. We disclose PHI when we release, transfer, or give access to PHI to other external persons or facilities. Except for the following circumstances we will not release your PHI without your written authorization.

- **Treatment-** We will use and/or disclose your PHI to provide chiropractic services, coordinate chiropractic care, and or help manage your health care and other medical services. For example, Atlas Chiropractic may discuss your PHI with another physician to better coordinate your chiropractic treatment while as a patient at Atlas Chiropractic. We may also disclose PHI to external persons or facilities that will be involved in your chiropractic treatment. For example, your primary care physician may need to be informed of aspects of the treatment you received here so that appropriate follow-up care is provided for you.
- **Payment** - Your PHI will be used and/or disclosed, as needed, to help obtain payment for your services. These uses/and or disclosures are often required to obtain payment from a third party. For example, your PHI may be released to your health insurance plan to determine which services may require pre-authorization and your PHI may be disclosed to obtain insurance authorization for such services before they are rendered.
- **Health Care Operations** – Your PHI may be used and/or disclosed, as needed, to aid us in everyday running of Atlas Chiropractic. We want to provide you and your family with the best quality of care. In order to help us do so, we may use your PHI for quality control reviews, internal performance reviews, training of new employees, and for other health care related activities. We may also use and/or disclose your PHI to provide information to you. For example; ***Continuation of treatment***: We may use and/or disclose your PHI to ensure continuation of care by checking on your progress or notifying you of received test results. ***Treatment Options***: We may use/or disclose your PHI to inform you of various treatment options/programs that may be of benefit to your care. ***Medical Benefit Services***: We may use/or disclose your PHI to inform you of various medical benefit services in the community that may be of use to you, for example, chiropractic educational classes, health promotion services, and/or insurance benefit programs you may be eligible. ***Birthday Cards/Appointment Notices***: We may use/or disclose your health information to provide you with an appointment reminder (such as voicemail messages, or leaving a message with a person at your residence, postcards, or letters). ***Open Room Adjusting***: We may use/or disclose your PHI to treat you in an open adjusting treatment room, which may involve several patients being seen at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not be adjusted in an open-adjusting environment, other arrangements will be made for you. ***Sign In Sheet:*** We will use/disclose your PHI regarding the sign-in sheet. Your signature will appear within eyesight of other patients being treated on the same day.

**Other Permitted/Required Uses and Disclosures –** We may use and/or disclose your PHI to the appropriate authorities in the following situations without your authorization:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

## Your Rights Regarding Your PHI

You have the right to receive documentation of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be granted with your written authorization. If you provide a written authorization for release of your health information, you have the right to revoke that authorization in the future.

Information that we use or disclose based on this privacy notice 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.

You have the right to inspect, amend, and/or copy your health information for as long as the information remains in our files. Requests to inspect, amend, and/or copy your health information are required to be in written form.

We are required by state and federal law to maintain the privacy of your file and the protected health information therein. We are also required to provide you with a copy of this privacy statement. We are also required by law to abide by the terms of this privacy contract.

We reserve the right to alter or amend the terms of this privacy statement. If this privacy statement is amended, we will notify you in writing as soon as possible. Any amendments will apply to all of your protected health information in our files.

If you have a complaint/inquiry regarding our privacy statement or our privacy practices, you should inquire with Dr. Clare McDaniel.

You also have the right to file a complaint with the Secretary of the Department of Health and Human Service. If you choose to file a complaint with this office or the Secretary of HHS, you are entitled to continue care without any discrimination from this office.

This statement is effective as of April 01, 2003. This statement and any amendments made hereto will expire seven years after the date upon which the record was signed. My signature below acknowledges that I have received a copy of this privacy statement.

__________________________ ________________________________

Printed Name Signature Date

***If you are a minor, or if you are being represented by another person**

__________________________ ________________________________

Representative's Printed Name Representative Signature Date

____________________________________________________________

Description of the authority to act on behalf of the member.