

HIPAA PATIENT CONSENT FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Consent and you are advised to do so. This authorization for release of information covers the period of healthcare from _____, 20____ to _____, 20____.

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The patient understands and agrees that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this consent. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

Protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes.

The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures that require the patient's prior written consent will then cease.

The Clinic may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by:

Printed Name – Patient or Representative

Signature Date

Relationship to Patient
(if other than patient)

Witness:

Printed Name – Clinic Representative

Signature Date

For Internal Use:

Patient Refused to Sign Patient unable to sign for the following reason: _____

FINANCIAL AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, BackBone shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

PATIENT SIGNATURE

INSURED'S SIGNATURE

DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to BackBone all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

SIGNATURE OF INSURED/GUARDIAN

DATE

BACKBONE

Wellness Center

HEALTH CONCERNS: Please list your top health concerns in order of priority.

- 1.) _____
- 2.) _____
- 3.) _____

TREATMENT GOALS: (Please circle) Minimal-Patch up Resolve Symptoms-Fix Cause Optimal Health & Wellness

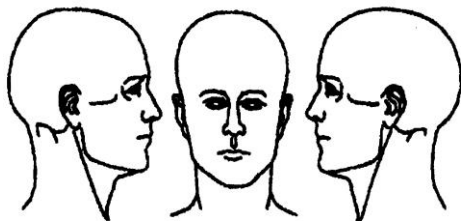
Are you interested in receiving more information regarding: (Please circle)

- | | | | |
|------------------------------|--|----------------|---------------------------|
| a. Stretching/rehabilitation | b. Nutrition | c. Acupuncture | d. Massage Therapy |
| e. Ergonomics | f. Detoxification | g. Herbs | h. Pediatric Chiropractic |
| i. Changing Body Composition | j. Lowering Cholesterol/BP/Triglycerides | | k. Metabolic Syndrome |

1. Have you been treated by a chiropractor/acupuncturist in the past? Yes/No
2. Did you have a good experience? Yes/No Please explain to us what you liked/did not like: _____
3. Do you exercise regularly? Yes/No How many times a week? _____
4. Are you healthier today than you were 5 years ago? Yes/No Why? _____
6. Does your current health situation prevent you from doing anything that you would normally enjoy doing? What?

7. In relation to your primary concern: Has another doctor treated you for this condition? Yes/No
If yes, whom? _____ Treatment? _____ X-ray/MRI? _____
8. If this is a recurrence, when was the first time you noticed? _____ # of episodes? _____
9. How did it originally occur? _____ Date: _____
11. Has it become worse recently? Yes/No/Same/Better/Gradually worse
12. How frequent is the condition? Constant Daily Intermittent Nightly only
13. Is this condition interfering with your: work/sleep/Daily routine, other: _____
14. Is there anything that can relieve the problem? Yes/No, Please describe: _____

Please shade/mark in your areas of discomfort on the models below.



Stabbing/Cutting- III Tingling -:::
 Burning- XXX Cramping - <<<
 Numbness - === Dull - ###



MEDICAL HISTORY

P = Present • N = Not Present • PN = if it has ever been present in the past

P	N	CONDITION	PN	P	N	CONDITION	PN	P	N	CONDITION	PN	P	N	ALLERGIES	PN
		Weakness				Muscle Pain				Seizures				Animal Dander	
		Fatigue				Muscle Weakness				Vertigo				Latex	
		Fever				Muscle Cramps				Dizziness				Food Allergies	
		Chills				Joint Stiffness				Tremors				Penicillin	
		Night Sweats				Joint Tenderness				Loss of Sensation				Pollen	
		Fainting				Spinal Curvature				Loss of Coordination				Second-Hand Smoke	
		Nervousness				Back Pain				Weak Grip				Grasses	
		Concentration Loss				Hot Joints				Paralysis				Sulfa Drugs	
		Dizzy Spells				Joint Swelling				Difficulty of Speech				Dairy Products	
		Irritability				Stiff Neck				Tingling				Perfumes	
		Depression				Soreness				Numbness				Hay	
		Memory Loss				Lumps				Pregnant					
		Loss of Sleep				Masses				Pacemaker					
		Headache				Apprehension									

P	N	DIAGNOSIS	DATE AND EXPLANATION OF CONDITION
		Cancer	
		Balance Problems	
		Stroke	
		Thyroid Problems	
		Asthma	
		Heart Attack	
		HIV	
		Angina/Chest Pain	
		Diabetes	
		Gout	
		Broken Bones	
		Arthritis	
		Serious Depression	
		Other	

SURGERY	YES	NO	YEAR	SURGERY	YES	NO	YEAR
Tonsils				WOMEN			
Colon				Breast			
Hernia				Uterus			
Appendix				Ovaries			
Gall Bladder				MEN			
Stomach				Prostate			
Heart				Other			
Kidney							
Other							
What other major injuries have you had? (Include Dates)							
What medications / vitamins are you currently taking?							
Hospitalizations:							
Family History of Illnesses:							

Marital Status ___ Married ___ Divorced ___ Single ___ Separated ___ Widowed

Number of Children: ___

Frequency of Exercise ___ Never ___ Rarely ___ Occasionally ___ Moderately ___ Regularly

Intensity of Exercise ___ Low Level ___ Medium Level ___ High Level ___ Competition Level

Sufficient Rest ___ Never ___ Rarely ___ Occasionally ___ Moderately

Hours of Sleep ___ ___ 10 or more hours

Well balanced diet ___ Never ___ Rarely ___ Occasionally ___ Moderately

Do you smoke?

___ No ___ Occasionally ___ 1 to 2 ___ 2 to 3 ___ 4 to 5 ___ More than 5 packs/day

Do you drink caffeinated beverages?

___ No ___ Occasionally ___ 1 to 2 ___ 2 to 3 ___ 4 to 5 ___ More than 5 drinks/day

Do you drink alcoholic beverages?

___ No ___ Occasionally ___ 1 to 2 ___ 2 to 3 ___ 4 to 5 ___ More than 5 5 drinks/day

Have you ever used street drugs? ___ Yes ___ No

Hobbies: _____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible). The treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future are employed by, working for or associated with, or serving as back-up for the Doctor of Chiropractic named below.

I have had an opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including to treatment at all.

I understand that there are some risks to chiropractic treatment including, but not limited to:

- | | |
|---|---|
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Increased symptoms and pain |
| <input type="checkbox"/> Dislocations | <input type="checkbox"/> No improvement of symptoms or pain |
| <input type="checkbox"/> Sprains/strains | <input type="checkbox"/> Infection (acupuncture) |
| <input type="checkbox"/> Burns/frostbite (physical therapy) | <input type="checkbox"/> Punctured lung (acupuncture) |
| <input type="checkbox"/> Worsening/aggravation of spinal conditions | <input type="checkbox"/> Other: _____ |

In rare cases, some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke and death. I do not expect the Doctor to anticipate all risks and complications and I wish to rely on the Doctor to exercise judgment during the course of the procedure(s) which the Doctor feels at the time, based upon the facts then known, are in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of my treatment for my current and future conditions.

To be completed by patient:

PRINTED NAME

SIGNATURE OF PATIENT

DATE SIGNED

PRINTED NAME OF DOCTOR OF CHIROPRACTIC

To be completed by Doctor or staff:

WITNESS TO PATIENT'S SIGNATURE

Translated by

To be completed by the patient's representative:

PRINT NAME OF PATIENT

PRINT NAME OF PATIENT'S REPRESENTATIVE

SIGNATURE OF PATIENT'S REPRESENTATIVE

AS: _____
RELATIONSHIP/AUTHORITY OF REPRESENTATIVE

DATE SIGNED

DATE SIGNED

DATE SIGNED