Family Wellness
CHIROPRACTIC
chirofamilywellness.com

Patient Intake Form

First Name: _____ Last Name: _____
Birthdate: _____ Sex: ___ M ___F Age: _____
Address: _____
City: _____State: _____ Zip:_____
Email: _____
Home Phone:_____Work Phone:_____Cell Phone: _____
Referred By: _____
Patient Employer: _____Occupation: _____
Marital Status: Single Married Divorced Other: _____
Spouse Name: _____ Children: _____
Have you had chiropractic care: Y / N

Reason for visit: _____
_____

How long have you had this condition? _____
Date of onset: _____
How did your problem begin? _____

How would you describe your pain?
____Sharp _____Soreness _____Throbbing _____Tingling _____Dull _____Spasm
____Stiffness _____Burning _____Ache _____Weakness _____Numbness ____Shooting

Since your problem began is the pain:
_____ Getting worse _____ Getting better _____ Staying the same

How would you rate the intensity of your pain? (circle number below)
0 1 2 3 4 5 6 7 8 9 10
(no pain) (moderate pain) (terrible/unbearable pain)

How often is the pain present?
___Constant (81-100%) ___Frequent (51-80%) ____Occasional (28-50%) ____Intermittent (25%or less)

Does coughing, sneezing or deep breathing aggravate your problem?_____
What aggravates your condition?_____

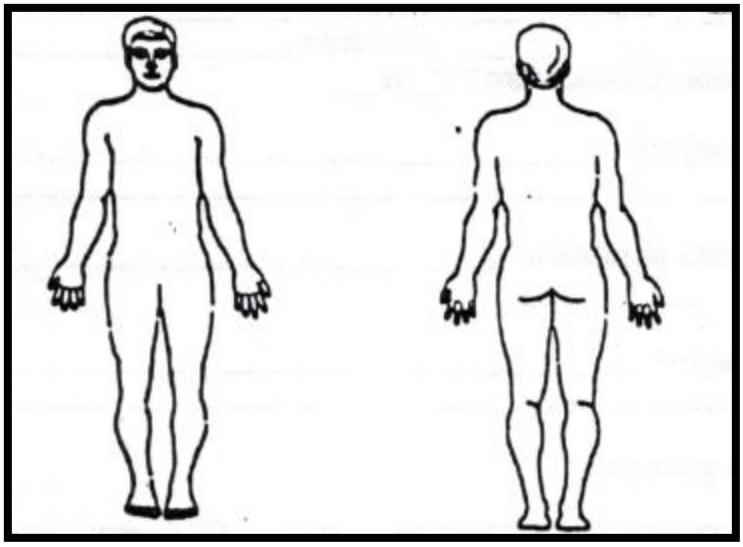
What has the lack of health kept you from doing in your life? _____

_____

What do you hope to achieve on your first visit with us today? _____

_____

Please indicate on the figures below what areas best represent your condition:



I will pay today by: _____Cash _____Check _____Credit Card
Card Type/Number: _____ Exp. Date: _____

I understand and agree that health and accident insurance polies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the chiropractic office will be credited on my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. Failure to make payment when requested is basis for legal action and I agree to pay all cost of collections including an attorney's fee, and hereby waive my rights of exemption under the laws of the State of Alabama and any other state. I understand that payment is due at the time of service and agree to pay (18% per annum interest on all accounts over thirty days). I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered me will be immediately due and payable. This signature shall suffice for all insurance forms.

I consent to clinic services that are ordered under the general and specific instructions of the Doctor. It is understood that all office records, test results, x-ray films, etc. concerning a patient's case are the doctor's property.

Patient Signature: _____ Date: _____
Guardian or Spouse Signature: _____ Date: _____

Consent to use or disclosure of Protected Heath Information (PHI) for payment, treatment and health care operations.

By signing below, you hereby consent for Family Wellness Chiropractic, LLC (the "Practice") to use or disclose information about you (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose of treatment, payment and health care operations. You may refuse to sign this consent form. You should read the Notice of Privacy Practices for PHI, available at the front desk, before signing this consent. The terms of the Notice may change from time to time. And you may always get a revised copy of it by asking the front desk for a copy.

You also have the right to request that the Practice restrict how your PHI is used or disclosed in carrying out our treatment, payment or health care operations. Please be aware, however, that the Practice is not required to agree to those requested restrictions. Should the Practice agree to your requested restrictions, though, the restrictions are binding.

Information about you is protected under federal law and you have the right to revoke this consent at any time. This revocation will not apply to action(s) the Practice has already taken in reliance on your consent (as determined by our privacy officer). Be signing below, you recognize that the PHI used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Family Wellness Chiropractic, LLC. may communicate information, including payment invoices and appointment reminders to me at the following address and/or phone numbers. I understand that I need not supply either, provided I do not wish to be contacted by the Practice. In such case, I agree to pay for all charges incurred during my visit at the time of service.

_____ The Practice may send correspondence to me at the address listed in my patient information.
_____ The Practice may leave messages at the following numbers:

_____ _____
_____ _____

I authorize the following person(s) to communicate with the Practice on my behalf:
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

_____ _____
Signature of Patient or Legal Guardian Date

Patient Consent to use or disclosure of Protected Health Information (PHI)

I, _____ , hereby state that by signing this Consent, I acknowledge and agree as follows:

1. Family Wellness Chiropractic, LLC (FWC) Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my Protected Health Information (PHI) necessary for FWC to provide treatment to me and also necessary for FWC to obtain payment for that treatment and to carry out health care operations. FWC explained to me that the Privacy Notice will be available to me in the future at my request. FWC has further explained to me my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this consent. FWC reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

2. I understand, that and consent to , the following appointment reminders or communications that will be used by FWC:

- Telephoning my home and/or office and leaving a message on my answering machine or with the individual answering the phone
- Birthday cards, thank you grams, E-mail messages or Sign-in sheets
- Other health related benefits or services that may be of interest to me

3. FWC may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for FWC to treat me an obtain payment for that treatment, and as necessary for FWC to conduct its specific health care operations.

4. I understand that I have the right to request how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, FWC is not required to agree to any restrictions that I have requested. If FWC agrees to a requested restriction, then the restriction is binding on FWC.

5. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that FWC has already taken action in reliance on this consent.

_____	_____
Name of Individual (printed)	Signature of Individual
_____	_____
Signature of Legal Representative*	Relationship
_____/_____/_____	_____
Date Signed	Witness

**Attorney-in-fact, Guardian, Parent of Minor*