Delmarva Chiropractic

Dr. Daniel G.J. Lane 1324 Belmont Ave Ste 102, Salisbury, MD 21804 Dr. David R. Brown

ABOUT YOU

Today's Date: _____

Full Name: _____

Prefer to be called: _____

Address: _____

_____

City: _____

State: _____ Zip: _____

SSN: _____-_____-_____

Birth Date: ____/____/____ Age: _____

Gender: ❑ Male ❑ Female

Home Phone: (_____) _____

Cell Phone: (_____) _____

Employer: _____

Employer's Address: _____

City/State/Zip: _____

Work Phone: (_____) _____

Occupation: _____

Do you prefer to receive calls at: ❑ Cell ❑ Home ❑ Work

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Separated ❑ Divorced

Email address: _____

1. Have you ever been to a chiropractor before? ❑ No ❑ Yes

   If so, explain? _____

2. How did you hear about our office? ❑ Ins. Company ❑ Friend/Relative – If so who: _____

   ❑ Yellow Pages ❑ Other: _____

IN EVENT OF EMERGENCY

Who Should We Contact? _____ Relationship: _____

Telephone Number: (_____) _____ Alternate Number: (_____) _____

INSURANCE INFORMATION

Company Name: _____ Insured's Name: _____

Insured's SSN: _____-_____-_____ Birth Date: ___/___/____ Employer of Insured: _____

ACCOUNT INFORMATION

I hereby give my authorization/consent to treat me or my minor child as named herein on this form. Our office policy requires **payment in full** for all services and goods rendered **at the time of your visit to the office**, unless other arrangements have been made with the Office Manager. I clearly understand and agree that all services and goods rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and/or treatment, any fees for professional services or goods rendered to me will be immediately due and payable. I hereby authorize payment of any and all benefits, medical or otherwise, to the physician for benefits due me for the services and/or goods rendered. I further authorize the physician and/or supplier to release my information as required to process any and all insurance claims. **I understand the above information in its entirety and hereby guarantee that this form was completed accurately to the best of my knowledge. I also understand that it is my responsibility to inform this office, in a timely manner, of any and all changes to this information.**

_____ _____

Patient Signature (Parent or Guardian Signature if Patient is a Minor) **Date Signed**

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Name: _____ Date: _____

Height: _____ Weight: _____ Children (list ages and sex): _____

HEALTH HISTORY

PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:
CIRCLE THE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS.

❑ AIDS	❑ Breast Lumps	❑ Epilepsy	❑ Measles	❑ Pacemaker	❑ STD
❑ Alcoholism	❑ Cancer	❑ Lymes Disease	❑ Multiple Sclerosis	❑ Pneumonia	❑ Stroke
❑ Anemia	❑ Chicken Pox	❑ Fibromyalgia	❑ Mumps	❑ Polio	❑ Tuberculosis
❑ Appendicitis	❑ Diabetes	❑ Goiter	❑ Pacemaker	❑ Rheumatic Fever	❑ Ulcers
❑ Arteriosclerosis	❑ Eczema	❑ Gout	❑ Parkinson's	❑ Rheumatoid Arthritis	❑ Other _____
❑ Asthma	❑ Emphysema	❑ Heart Disease	❑ Prostate	❑ Scarlet Fever	❑ Other _____

1. Please list any medications/supplements/vitamins you are presently taking: _____
2. Please list all previous surgeries and hospitalizations (include dates): _____
3. Please list all allergies: _____
4. Please list all dates of motor vehicle collisions, if any: _____
5. Please list all fractures and dislocations: _____
6. **Women Only** – Are you pregnant? ❑Yes ❑No Taking Birth Control? ❑Yes ❑No Last menstruation? ____/_____/_____

Date of Last (Approx.)

_____ Physical Exam
_____ Blood Test
_____ X-ray
_____ MRI
_____ CT Scan
_____ Urine Test

	None	Light	Moderate	Heavy
Alcohol	❑	❑	❑	❑
Caffeine	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑

1. Sleep Position ❑ Side ❑ Stomach ❑ Back
2. Do you wear orthotics? ❑ Yes ❑ No
3. Rate your stress level _____ (0 = no stress, 10 = severe stress)

CURRENT COMPLAINTS

Please check the appropriate box for any of the following symptoms, which you now have or have had previously.
THIS IS A CONFIDENTIAL HEALTH REPORT

CARDIO-VASCULAR	RESPIRATORY	SKIN	GENITO-URINARY
❑ Hardening of the arteries	❑ Chronic cough	❑ Bruise easily	❑ Bed-wetting
❑ High blood pressure	❑ Difficultly breathing	❑ Dryness	❑ Blood in urine
❑ Low blood pressure	❑ Wheezing	❑ Skin eruptions (rash)	❑ Frequent urination
❑ Pain over heart	❑ Spitting up blood	❑ Discolorations	❑ Kidney infection
❑ Poor circulation	❑ Spitting up phlegm	❑ Varicose veins	❑ Kidney stones
❑ Rapid heartbeat			❑ Painful urination
❑ Chest pain			❑ Prostate problems
			❑ Pus in urine

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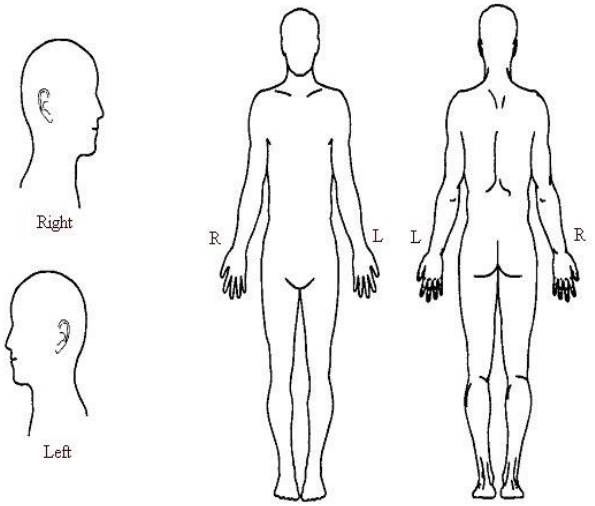
EENT	GASTRO-INTESTINAL	FOR WOMEN ONLY	NERVOUS SYSTEM
❑ Eye pain/strain	❑ Appetite changes	❑ Back ache or cramps	❑ Numbness/tingling
❑ Vision problems	❑ Difficulty chewing/swallowing	❑ Excessive menstrual flow	❑ Loss of feeling
❑ Ear pain	❑ Excessive thirst	❑ Hot flashes	❑ Paralysis
❑ Ear noises	❑ Nausea	❑ Irregular cycle	❑ Dizziness
❑ Ear discharge	❑ Vomiting blood	❑ Menopausal symptoms	❑ Fainting
❑ Hearing loss	❑ Abdominal pain	❑ Painful menstruation	❑ Headaches
❑ Nose pain	❑ Diarrhea	❑ Vaginal Discharge	❑ Loss of memory
❑ Nose bleeds/discharge	❑ Constipation	❑ Vaginal Pain	❑ Muscle jerking
❑ Nasal obstruction	❑ Bloody/black stool	❑ Breast Pain	❑ Loss of taste/smell
❑ Sore mouth	❑ Hemorrhoids	❑ Miscarriage	❑ Cold feet/hands
❑ Sore throat	❑ Liver problems		❑ Convulsions
❑ Hoarsens	❑ Gallbladder problems		❑ Confusion
❑ Difficult speech	❑ Weight trouble		❑ Depression
❑ Sinus infection			❑ Insomnia
❑ Jaw pain			

MUSCULOSKELETAL		PAIN, NUMBNESS, CRAMP	
❑ Low back pain	❑ Stiff joints	❑ Back	❑ Hands
❑ Mid back pain	❑ Sore muscles	❑ Neck	❑ Hips
❑ Neck pain	❑ Weak muscles	❑ Head	❑ Legs
❑ Arm problems	❑ Muscle spasm	❑ Shoulders	❑ Knees
❑ Leg problems	❑ Walking problems	❑ Arms	❑ Feet
❑ Swollen joints	❑ Sciatica	❑ Elbows	❑ Other _____
❑ Painful joints	❑ Arthritis		
	❑ Other _____		

PLEASE OUTLINE ON THE DIAGRAM AREAS OF DISCOMFORT USING THE SYMBOLS BELOW:

A = Aching	N = Numbness
B = Burning	R = Radiating
C= Cold	S = Stabbing
H = Hypersensitivity	T = Tingling



Out of all your concerns, which is the <u>most troublesome</u> to you? _____

Please indicate the level of pain and/or discomfort you are experiencing to the above condition.

No Pain **0 1 2 3 4 5 6 7 8 9 10** **Worst pain imaginable**

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CONSENT TO CHIROPRACTIC SERVICES

PAYMENT AND INSURANCE INITIALS: _____

I understand and agree that the health and accident insurance policies are an arrangement made between the insurance carrier and myself. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to pay directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible both for payments, and knowledge of my insurance policy. Delmarva Chiropractic is not responsible for such information and will assume no responsibility for monies owed due to insurance cessation. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

CONSENT TO CHIROPRACTIC SERVICES INITIALS: _____

I hereby request and consent to chiropractic manipulations and other procedures including various modes of physical therapy, diagnostic x-rays, and/or tests by Delmarva Chiropractic and their staff who now, or in the future treat me while employed by this office. I have had to discuss with Dr. Lane/Dr. Brown and/or with other clinic personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of chiropractic, there are some risks to treatment including but not limited to fractures, disk injuries, strokes, dislocations, and strain/sprains. I do not expect the doctor to be able to anticipate or explain all risks and complications, and will rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me the full above consent and have also had the opportunity to ask questions about it's content, and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic and/or employed staff.

FEMALE PATIENTS INITIALS: _____

This is to certify that to the best of my knowledge I am NOT pregnant and the Delmarva Chiropractic has my permission to take x-rays, and or perform all necessary test. Beginning date of your last menstrual period _____.

Signed: _____ Date: _____

PATIENT NOTIFICATION OF FINANCIAL RESPONISBILITY

I understand that I may be financially responsible for any charges incurred at this office, including co-payments, deductibles, and charges denied or not covered by my insurance company.

I realize that my care may be subject to pre-authorization by my insurance company, and I accept all responsibility for any treatments, which are determined to be not medically necessary. I understand Delmarva Chiropractic will submit all required documentation to the insurance company, or their designee, so that a review relative to determination of medical necessity can be made for subsequent treatment. I understand that both Delmarva Chiropractic and I will receive direct notification from the insurance company, or their designee, and will be advised as to whether additional treatment has been approved or denied and the number of visits that have been approved for a specified time period. Charges for services determined to be not medically necessary by the insurance company will be my responsibility.

Insurance policy limitations are per individual insurance policy plans, as are co-payment, co-insurance, deductibles, and/or referrals.

Self-pay patients are required to pay at time of service, unless other arrangements have been made in advance with the business manager.

Balances outstanding more than 90 days will incur a 7% interest charge for every 30 days outstanding. In the event an account goes to collection, appropriate attorney fees and court costs will be added to the balance as well as any additional interest subsequent to the length of the balance.

We accept Visa, MasterCard, Check, Cash, and varied insurance plans. Please check with the receptionist if you have any questions. There is a return check fee of $35.00.

I have read and understand my obligations for payment for care at Delmarva Chiropractic.

_____ _____

Print Name Date

_____ _____

Signature (Patient, Parent or Guardian) Witness

MEDICAL AUTHORIZATION

Patient's Name: _____

Date of Birth: _____

Social Security Number: _____

I, _____, hereby authorize the said clinic for obtaining all information relative to my physical and/or mental condition, past, present, or future from all doctors and other healthcare professionals who have treated me, and all hospitals and other healthcare institutes, in which I have ever been a patient.

_____ _____

Patient's Signature Date

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

This practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from this practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

- The Practice may use and/or disclose your PHI fro the following purposes:

(a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for lower back pain may need to know the results of your latest physician examination by this office.

(b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can be determined whether or not it will cover the treatment expense.

© Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

- The Practice may also use and/or disclose your PHI without your specific authorization in the following additional instances:

(a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate - To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -

(i) for the purpose of obtaining or rendering emergency treatment to you if the opportunity for you to object cannot be obtained due to your incapacity or emergent treatment circumstances and the treatment is consistent with your prior expressed preferences and is in your best interest; or

(ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Public Health Activities - Such activities include, for example, information collected by public health authority, as authorized by law, to prevent or control disease.

(e) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(f) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

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(g) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(h) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes your death was the result of criminal conduct.

(i) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of

identifying you or determining your cause of death.
(j)Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.

(j) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.

(k) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(l) Specialized Government Function - This refers to disclosures of PHI that relate primarily to military and veteran activity.

(m) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(n) (n)National Security and Intelligence Activities - The Practice may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.

(o) Military and Veterans - If you are a member of the armed forces, the Practice may disclose your PHI as required by the military command authorities.

APPOINTMENT REMINDER / MISC. LITERATURE ETC.

- The Practice may, from time to time, contact you to provide appointment reminder or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone. We may also send miscellaneous literature such as thank you cards, thank you for your referral cards, sympathy cards, congratulatory cards, office newsletters, insurance forms, etc.

DIRECTORY/SIGN-IN LOG

- The Practice maintains a director of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

FACSIMILE TRANSMITTALS / TELEPHONE TRANSMITTALS

- The Practice uses the telephone and facsimile machine to transmit PHI to other entities that may be privy to such information. Telephone calls may be inadvertently overheard by others as well fax transmittals inadvertently seen by others.

FAMILY/FRIENDS

- The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

  (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

  (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

- Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

- You have the right to:

(a) Revoke any Authorization in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications or PHI be alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing, or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

(e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available0, if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of you PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. The first request should indicate in what form you want the list (such as paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

(h) Complain to the Practice or to the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

(i) To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer, at 410-219-5155.

PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information than is provided for under federal law. In particular, the Practice is required to comply with certain State statutes. These can be furnished to you if you do so request.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the practice's Privacy Notice that has an effective date of ___/___/___.

_____ _____

Name of Individual (Printed) Signature of Individual

Date Signed: _____/_____/_____