

Anthony Rosania D.C.

Mobile Chiropractic Care Center

Phone 973-768-5100

Fax 732-537-9622

Welcome to Anthony Rosania D.C. Mobile Chiropractic Care Center

Thank you for choosing us as your chiropractor. We realize that you have many choices for chiropractic care and are delighted that you have chosen us to provide those services. Please be assured that our staff is highly qualified and well trained to provide your care.

Please read each numbered section. Any of our staff will answer any question you may have about this information.

1. Please read and fill out all the attached paper work.
 - Pages 2-4 are your medical rights. The privacy brochure is yours to keep
 - Page 5 states that you received your privacy notice. There is a place, on this form, to indicate if you want us to share any information with other people (e.g. spouse, lawyer, and children.) and where we can leave information. **Fill out and return to the Dr.**
 - Page 6 is your information (e.g. name, address, and telephone.) **Fill out and return to the Dr.**
 - Pages 7-8 cover your past medical history. **Fill out and return to the Dr.**
2. If you were referred here from a physician, we will be contacting him/her, with your approval, of your progress. Please inform us of your next scheduled appointment with your Doctor.
3. Please be courteous of your fellow patients by being on time for your appointments. If you are late, your appointment may be rescheduled. If you find that you can not be on time, please give us a call, so we may make adjustments to our schedule.
4. If you are unable to keep an appointment due to illness or other conflict, please notify us at least 24 hours in advance. We can then reschedule your appointment for another time.
5. We want to keep your schedule appointment time. However, please bear in mind that priority scheduling will be given to those patients that are emergency cases. Also, at times, treating a patient may take slightly longer than expected. In these situations you may have to wait. We are certain that you can understand this and your cooperation and flexibility are greatly appreciated. You will be notified in such situations.
6. You will need to follow the schedule outlined by the doctor to achieve your treatment goals. Repeated cancellations/missed appointments may result in being discharged from care.
7. In case of bad weather, please call the office to confirm your appointment.
8. If you have a concern about your care or treatment that you receive at our clinic, please speak to the doctor.
9. If you have a change in insurance it is your responsibility to inform our staff. If you fail to notify the office of any changes in your insurance you may be held responsible for any charges for services rendered.
- 10. If you are hospitalized or suffer a change in your medical status you must report this to the doctor.**

We hope you will be pleased with our care and refer your family and friends to us. Thank you again for choosing us and we look forward to serving you.

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Notice of Privacy Practice

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. If you have any questions about this Notice please contact our Privacy Contact who is Carey P. Smith

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Your physician will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or

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disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation. *[This section will only be applicable to larger practices or those practices that operate facilities.]*

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgement, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

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Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by placing it in writing to the practice's privacy officer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, **Carey P. Smith** at: (973)275-1860 csmith@medical-billingonline.com for further information about the complaint process. This notice was published and becomes effective on **April 14, 2003**

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have been given the chance to review and receive a copy, if so desired, of the Privacy Notice.

Patient or Personal Representative

Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

RELEASE OF CONFIDENTIAL INFORMATION

I, _____, am aware that Anthony A Rosania, DC holds my medical information as confidential. My medical care and test results cannot be disclosed or discussed with anyone but myself. I understand this policy and by my signature below I agree to Anthony A Rosania, DC doctors and staff to communicate with the people I have listed below. This permission will stand until changed by myself. I understand that it is my responsibility to forward any changes in writing if I desire to change this release and that verbal changes may not be honored.

Anthony A Rosania, DC may leave information for me on my answering machine or voice mail.

Home: YES _____ NO _____ Work: YES _____ NO _____

Cell: YES _____ NO _____ Fax: YES _____ NO _____

Email: YES _____ NO _____

My medical condition and bills may be discussed with:

NAME	PHONE #	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand this information will stay in my permanent medical record until I give written notice otherwise

Patient Name or Personal Representative (Printed)

Signature

Relationship of Personal Representative

____/____/____
Date

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WELCOME TO ROSANIA CHIROPRACTIC CENTER

In order to serve you properly, we will need the following information. **Please print clearly.** All information will be confidential.

1) Date: _____ Patients name: _____
First MI Last

Address: _____
Street City State ZIP

Home phone: _____ Cell: _____ Work: _____

SSN: _____ Male Female Birthdate: _____

Patient's or parents employer: _____

Work Address: _____
Street City State ZIP

Minor Single Married Divorced Widowed Separated

Is the Patient the primary insured? Yes (If yes skip to # 3) NO

Insurance Information:

2) Insured/ Spouse's/ Parent's name: _____
First MI Last

Address: _____
Street City State ZIP

Home phone: _____ Cell: _____ Work: _____

SSN: _____ Male Female Birthdate: _____

Insured/ Spouse's/ Parent's employer: _____

Work Address: _____
Street City State ZIP

3) Whom may we thank for referring you? _____

Emergency Contact: _____ Phone: _____

PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD, FRONT AND BACK, AND ANY ADDITIONAL INSURANCE INFORMATION YOU MAY HAVE

I understand that it is my choice that I treat with Anthony Rosania DC. I also understand that Dr. Rosania uses a tape-recorder to dictate notes and that parts or all of my treatment session may be tape-recorded. I also understand that I am personally responsible for all charges for services rendered to me, or my child, in connection with this matter. I will make payment myself within a reasonable period of time after treatment has been completed. If my account is placed in collections I understand that I am responsible for attorney fee, collections and court costs. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I assign to Anthony Rosania DC any and all rights and benefits under any insurance contracts, for payments of claims rendered by the doctor. I also hereby authorize the doctor to file insurance claims on my behalf and direct all payments of insurance benefits otherwise payable to me directly to the doctor.

X _____
Patient's (or Guardian's) Signature Date

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In order to serve you properly, we will need the following information. **Please print clearly.** All information will be confidential.

Name: _____ Date: _____

Date of birth: _____ Occupation: _____

Why are we seeing you?: _____

OPERATIONS AND PROCEDURES (Please write the date(s) of any procedure you have had.)

Tonsillectomy Date _____ Gall Bladder Date _____ Back Operations Date _____

Tubes in Ears Date _____ Appendectomy Date _____ Female Organs Date _____

Rectal Surgery Date _____ Sinus Date _____ Hernia Date _____

Thyroid Date _____ Stomach Date _____

Other (please state procedure and dates) _____

LIST ANY ACIDENTS OR FALLS: (Please List Type And Date)

CAR &/or MOTERCYCLE _____

SPORTS _____ OTHER _____

ANY BROKEN BONES OR DISLOCATIONS: (Fractures) _____

Ever On Crutches? No Yes If So, Why? _____

Have You Ever Had A Spinal Injection or Spinal Tap? Yes No

Have You Ever Had A Loss Of Memory? Yes No Have You Ever Been X-Rayed? Yes No

If So, When? _____ Why? _____

Are You Presently Taking Any Medication-Prescription Or Over-The-Counter? Yes No

If So, What Drugs? _____

Have you ever had any of the following? (Check, if yes)

- | | | | |
|--|--------------------------------------|---|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Infection | |

FAMILY HISTORY (Check, if there is a history)

	DIABETES	HEART DZ	KIDNEY	CANCER	BACK
MOTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FATHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BROTHER (# OF ____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SISTER (# OF ____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS:

Smoking: No Yes sometimes _____ pks/day.

Drinking: 1) Alcohol No Yes sometimes _____ drinks/day

2) Coffee No Yes _____ Cups/day

EXERCISE:

NONE MILD MODERATE DAILY

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PLEASE ENTER: 1 (PRESENTLY) or 2 (previously), IN FRONT OF THE FOLLOWING SIGNS AND SYMPTOMS. A COMPLETE HISTORY AND UNDERSTANDING OF YOUR HEALTH STATUS WILL FACILITATE CARE.

GENERAL SYMPTOMS

Headaches Fever Chills Dizziness Fainting Convulsions
 Fatigue Nervousness Loss of sleep Loss of Weight Night Sweats
 Numbness or pain in arms/hands/legs/feet Neuralgia Chest Pain

GASTRO-INTESTINAL

Poor Appetite Poor Digestion Excessive Hunger Belching or Gas
 Nausea Vomiting Vomiting with blood Pain over Stomach Constipation
 Jaundice Colon Trouble Hemorrhoids Liver Trouble
 Gall Bladder Trouble Diarrhea

EENT

Near-sighted Far-sighted Poor Vision Crossed Eyes Pain in Eyes
 Deafness Earache Ear Noises Ear Discharges Nasal Obstructions
 Nose Bleeds Frequent colds Sore Throat Hoarseness Hay Fever
 Asthma Enlarged Thyroid Tonsillitis Sinus Trouble

RESPIRATORY

Chronic Cough Spitting Blood Spitting Phlegm Difficulty Breathing

GENTO-URINARY

Frequent Urination Painful Urination Blood in Urine Kidney Infection
 Bed Wetting Prostrate Trouble Inability to Control Urine

MUSCLE AND JOINTS

Weakness Twitching Stiff Neck Back Ache Swollen Joints
 Tremors Foot Trouble Painful Tail Bone Pain between the shoulders
 Hernia Spinal Curvature

CARDIO-VASCULAR

Rapid heart Slow Heart High Blood Pressure Low Blood Pressure Strokes
 Pain Over Heart Previous Heart Problems Swelling of Ankles Poor Circulation

SKIN/ALLERGIES

Skin Eruptions Itching Bruising Easily Dryness/Boils Eczema
 Sensitive Skin Hives or Allergies (To what?) _____
 Medications (To What?) _____

WOMEN ONLY

Painful Periods Excessive Flow Irregular Cycles Hot Flashes
 Cramps or Back pain Miscarriage Vaginal Discharge Pregnant at this Time
Date of Last Pap _____ By whom _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount paid directly to the Doctor's Office will be credited to my account on receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I terminate my care and treatment, and any fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to treat my condition, as he deems appropriate through the use of manipulation throughout my spine. I understand and agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient/Guardian's Signature _____ Date _____