CONFIDENTIAL PATIENT INFORMATION

This information is confidential. In order for us to understand your health problems properly, please complete these forms and bring them to your first appointment.

Date: Chart #: SS#:
Name: Home Phone:
Address:
Birth date: Marital Status: S M W D # of Children_____
Occupation_____ Employer_____
Address_____ Office Phone_____
Name of Spouse_____ Occupation_____
Employer_____ Office Phone_____
Other Nearest Relative_____ Phone_____

Please Circle Your Symptoms (Circle all that currently apply):

Neck Pain	Mid Back Pain	Low Back Pain	Headaches/Head Pain
Shoulder Pain	Elbow Pain	Wrist Pain	Arm/Hand Pain or Numbness
Rib Cage Pain	Hip Pain	Knee Pain	Thigh/Leg Pain or Numbness
Foot/Ankle Pain	Chest Pain	Groin Pain	

Other:_____

DOCTORS CONSULTED FOR THIS CONDITION:

Hospital Name_____

Doctor Name_____ When consulted_____

Present family doctor_____ Last physical exam_____

FINANCIAL INFORMATION:

Health Insurance Company_____
Policy #_____ ID#_____ Insured_____

Attorney name_____

WHAT SURGERIES HAVE YOU HAD?

_____

ANY OTHER SERIOUS ACCIDENTS AND FALLS? (AUTO, WORK RELATED, HOME, LEISURE, SPORTS, OTHER)

_____

BROKEN BONES, DISLOCATIONS?

_____

MEDICATIONS AND/OR SUPPLEMENTS YOU TAKE OR WERE PRESCRIBED:

_____

DISEASE/ILLNESS YOU HAVE BEEN DIAGNOSED WITH:
(Diabetes, Heart Disease, High Blood Pressure, Stroke, Asthma, Ulcers, Cancer, Arthritis, Depression, Etc)

_____

WORK/LEISURE ACTIVITIES (WHAT DO YOU DO FOR YOUR JOB / YOUR FREE TIME)

_____

Financial Informed Consent

RE: Non-Participation in Managed Care
Usual Customary and Reasonable Fees
Insurance Partial Payments

To avoid confusion regarding the financial arrangements in our office this Financial Informed Consent form has been given to you for review and signature. Please review each section below, confirming your understanding and acceptance of the statements.

I. I have been informed that Advanced Spinal Care, LLC may not contract with my managed care plan.

II. I have been informed and agree that the bill for chiropractic services are my responsibility and I am obligated to pay the bill regardless of the outcome of my case. My financial responsibility is not contingent upon favorable settlement, judgement, or verdict by which I may eventually recover.

III. I have been informed and agree that, by acceptance of a partial payment from a third party, Advanced Spinal Care, LLC does not accept the partial payment as payment in full and will balance bill for any outstanding balance.

IV. I can review the fee schedule posted in the office at request and agree to receive and pay for services regardless of any third party determination as to the reasonableness of said fees or length of care.

V. I have been informed and agree that while Advanced Spinal Care, LLC may bill collateral sources on my behalf, no representation has been made by Advanced Spinal Care, LLC regarding the likelihood of payment from these sources. The full payment, partial payment or non-payment from these sources will have no effect on the total balance for services rendered by Advanced Spinal Care, LLC. Examples of collateral sources include med-pay benefits, basic reparations benefits, managed care organizations, group health insurance.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the financial policies. I have discussed it with the staff and have had my questions answered to my satisfaction. By signing below I state that I have weighted the financial benefits and consequences involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the financial arrangements, I hereby give consent to that treatment.

PATIENT HAD THE FOLLOWING QUESTIONS AND WAS SUPPLIED WITH THE FOLLOWING ANSWERS:

COMMENTS:_____

_____

_____

_____ _____
Printed Name Date

_____ _____
Signature of Patient or Guardian (minor only) Date

INFORMED CONSENT

The primary treatment used by the doctors of chiropractic is the spinal adjustment. I will use that procedure to treat you.

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT

I will use my hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "POP" or "CLICK" much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

THE MATERIAL RISKS INHERENT IN CHIROPRACTIC ADJUSTMENT

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications Include: fractures, disc injuries, dislocations, and muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. 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. Some patients will feel some stiffness and soreness following the first few days of treatment.

THE PROBABILITY OF THOSE RISKS OCCURRING

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

ANCILLARY TREATMENT

In addition to chiropractic adjustments (manipulation) you may receive supportive treatments which will further assist in the management of your condition. While the risk of complication is low there is the possibility of side effects such as burns, soreness, skin irritation, etc. Some of the additional treatments which may be provided include hot moist heat, diathermy, ultrasound, TENS, electrical muscle stimulation, interferential therapy as well as multiple other modalities which have thermal, mechanical and chemical effects.

THE AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS

Other treatment options for your condition include:

-Self-administered, over-the-counter analgesics and rest.
-Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
-Hospitalization
-Surgery

RISKS INHERENT IN SUCH OPTIONS AND THE PROBABILITY OF SUCH RISKS OCCURRING

-Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependant upon the patients general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects form long term use of over-the-counter medicines.

-Prescription muscle relaxants and pain-killers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependant upon the patient's general health, severity of the patient's discomfort, pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks - some with rather high probabilities.

-Hospitalization in conjunction with other care bears the additional risks of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependant upon unknown variables.

-The risk inherent in surgery includes adverse reaction to anesthesia, iatrogenic mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

THE RISKS AND DANGERS ATTENDANT TO REMAINING UNTREATED

-Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighted the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give consent to that treatment.

_____ _____

Name DATE

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE

_____ _____

WITNESS SIGNATURE DATE

CONDITION OF PATIENT AT TIME OF CONSENT PROCESS

Based on my personal observation and direct conversation with the patient, I conclude that throughout the consent process the patient was:

[ ] Oriented as to time and place
[ ] Coherent and lucid
[ ] Receiving medication but unimpaired
[ ] Able to understand the language used
[ ] Assisted in understanding by use of interpreter
(interpreter's name:_____)
[ ] Assisted in consent process by family members:

_____ _____

Name Relationship

[ ] Assisted in consent by staff members:

_____

Name

PATIENT HAD THE FOLLOWING QUESTIONS AND WAS SUPPLIED WITH THE FOLLOWING ANSWERS:

COMMENTS:_____

I certify that the above accurately describes the consent process in the above case

_____ _____

SIGNATURE OF DOCTOR **DATE**

Financial Arrangement

Reports, Doctors Lien, Records Release, Assignment, Authorization

1. I hereby assign to **Advanced Spinal Care, LLC** my rights to receive health care payments from negligent parties or from insurance companies. Payments should be made to **Advanced Spinal Care, LLC, 111 West Main Street, Meriden, CT 06451**
2. I do hereby authorize **Advanced Spinal Care, LLC** to furnish my attorney with a full report of the examination, diagnosis, treatment, prognosis, etc. of myself with regard to the accident in which I was involved.
3. I authorize **Advanced Spinal Care, LLC** to release any information to any insurance company, provider, adjuster, or attorney that will assist with the payment of a claim.
4. **I hereby authorize and direct my attorney to pay directly to and pay such sums as may be due and owing for services rendered me, by reason of this accident and or any other matter which are due to Advanced Spinal Care, LLC and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect and pay Advanced Spinal Care, LLC**.

I understand that a letter of protection is required for one or more of the following reason(s)

- Basic Reparation Benefits or Med Pay may not be available or cover the necessary expenses.
- My group health benefits may have policy limitations which do not cover the cost of my necessary treatment.
- **Advanced Spinal Care, LLC** may not participate with my managed care organization (MCO).
- **Advanced Spinal Care, LLC** may participate with my MCO, however, I understand that services may be offered to me which are not included in the basic policy benefits. If contracted, **Advanced Spinal Care, LLC** will only bill for services which are beyond the policy guidelines as defined by my MCO.
- If I have no collateral or third party source of payment, the courtesy of credit from **Advanced Spinal Care, LLC** will be extended only when accompanied by a letter of protection.

5. I hereby give a lien on my case to **Advanced Spinal Care, LLC** against any and all proceeds of any settlement, judgement or verdict which may be paid to **Advanced Spinal Care, LLC**, as a result of the injuries for which I have been treated or injuries in connection therewith.
6. I understand that the bill for chiropractic services are my responsibility and I am obligated to pay the bill regardless of the outcome of my case. My financial responsibility is not contingent upon favorable settlement, judgement or verdict by which I may eventually recover. I have been informed that by acceptance of a partial payment from a third party Advanced Spinal Care, LLC does not accept the partial payment as payment in full and will balance bill for any outstanding balance. I have reviewed the fee schedule posted in the office and agree to receive services regardless of any third party determination as to the reasonableness of said fees or length of care. I acknowledge that this agreement is made solely for additional protection and in consideration of the courtesy of Advanced Spinal Care, LLC awaiting payment.
7. If a dispute should arise regarding the bills for services rendered by **Advanced Spinal Care, LLC,** I instruct my attorney to hold the disputed amount until the dispute is resolved.
8. I have been advised that if my attorney does not comply with my instructions to protect the interests of **Advanced Spinal Care, LLC** the courtesy of credit will not be extended. In the absence of a letter of protection **Advanced Spinal Care, LLC** will not await payment and will require me to make full payment on my account and keep same on a current basis, all services being due on the date services are performed.

_____ _____

Name Date

SECURITY AGREEMENT & ASSIGNMENT OF
AN INTEREST IN A PESORNAL INJURY CLAIM

Name: _____

In exchange for good and valuable consideration, services provided by Advanced Spinal Care, LLC and the promise to provide services by Advanced Spinal Care, LLC, the receipt of which is hereby acknowledged, I hereby:

1. Grant a lien to Advanced Spinal Care, LLC for its professional services, medical bills and charges for any and all treatment whatsoever, and costs against any and all settlement or judgment arising from my personal injury claim as a result of my accident. Cost such as medical report fees and record copying fees, which are incurred by Advanced Spinal Care, LLC in providing services to my attorney, and me will be deducted from any net recovery at the time of settlement or verdict in my personal injury case.

2. Assign and interest to Advanced Spinal Care, LLC for its professional services, medical bills and charges for any and all treatment whatsoever, and costs against any and all settlement or judgment arising from my personal injury claim as a result of my accident. Cost such as medical report fees and record copying fees, which are incurred by Advanced Spinal Care, LLC in providing services to my attorney, or me will be deducted from any net recovery at the time of settlement or verdict in my personal injury case.

3. Assign my rights to receive health care payments from negligent parties or from insurance companies. Payments are made to Advanced Spinal Care, LLC, 111 West Main Street, Meriden, CT 06451.

4. Authorize and direct my attorney to pay from my personal injury proceeds such sums as may be due and owing for services rendered to me, by any reason which are due to Advanced Spinal Care, LLC and to withhold such sums from any settlement, judgment or verdict from disbursement to me as may be necessary to adequately protect and pay Advanced Spinal Care, LLC.

5. If the parties cannot agree upon the reasonableness of a bill or costs, or a dispute arises, I agree and understand that my attorney will be required under Professional Rule of Conduct 1.15(b) to hold the amount of money in dispute. If the parties cannot agree upon the reasonableness of a bill or costs, or a dispute arises, then the parties agree, and I, herby, agree and stipulate to participate in binding arbitration within thirty days of receipt of personal injury proceeds by my attorney. I further agree to have the chairman of the Connecticut Chiropractic Association serve as the sole arbitrator of the disputed dollar amount. The parties agree to be bound by the arbitrator's decision. The parties agree to split (fifty/fifty) the costs of arbitration.

I understand that the bill for chiropractic treatment and services are my responsibility and I am obligated to pay the bill regardless of the outcome of my case. My financial responsibility is not contingent upon a favorable settlement or judgment of a personal injury claim. I have been informed that by acceptance of partial payment from a third party Advanced Spinal Care, LLC does not accept the partial payment as payment in full. When partial payment occurs it has been explained to me that Advanced Spinal Care, LLC will balance bill me for any outstanding balance. I have reviewed the fee schedule posted in the office and agree to receive services and be responsible for my bill. I acknowledge that this agreement is made for additional protection and in consideration of the courtesy of Advanced Spinal Care, LLC awaiting payment. I have read this document and understand it.

_____ _____
Signature Date

_____ _____
Witness Date

Notice of Privacy Practices

ADVANCED SPINAL CARE, LLC

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
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, to pay your health care bills, to support the operation of Advanced Spinal Care, LLC, and any other use required by law.

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. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. 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 Advanced Spinal Care, LLC. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical staff, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical personnel 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. 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 may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: 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.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to object unless required by law.

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.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. 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.

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. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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 alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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.**

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We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature_____ Date_____