**Schnack Chiropractic Center, S.C.**

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT; PAYMENT AND HEALTHCARE OPERATIONS.

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

1. The Practice's 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 the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has farther explained 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

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home or voice mail at work and leaving a message on my answering machine, voice mail or with the individual answering the phone.

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

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

6. 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 the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

| _____ | _____ | _____ |
|---|---|---|
| Printed Name of Individual | Signature of Individual | Date |

| _____ | _____ | _____ |
|---|---|---|
| Signature and Relationship of Legal Representative | Date | Witness |

SCHNACK CHIROPRACTIC CENTER, S.C.

PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

1. I, _____ hereby authorize _____ to use and /or disclose to Schnack Chiropractic Center, S.C. the following specific protected health information: X-ray, MRI, CT, Bone Scan, Bone Density Tests, other procedure reports, treatment notes, of _____ .

2. I understand that this authorization is valid for seven years.

3. I understand that the purpose or use of the disclosure I am granting is to complete a medical history and gather information which will help in establishing a treatment plan.

4. I expressly acknowledge that this authorization is voluntary.

5. There are no limitations I place on this release.

6. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

7. I understand that this authorization may be revoked by the authorizer, in writing, at any time. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

8. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy laws; such as to another health care provider, insurance company or attorney.

9. I understand that I may see and copy the information described in this form, if I ask for it, and that I may get a copy of this form after I sign it, if I ask for it.

10. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

11. This authorization is valid as of____/____ / ____, the date I have signed below.

_____ _____ _____
Printed Name of Individual Signature of Individual Date

_____ _____ _____
Signature of Legal Rep, (parent, guardian) Date Witness

# CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____ by Monica E. Schnack, D.C., Matthew R. Groves, D.C., and/or other licensed doctors of chiropractic who may be employed by or engaged in practice at Schnack Chiropractic Center, S.C.

I have had an opportunity to discuss with Monica E. Schnack., D.C., Matthew R. Groves, D.C., or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic services is very low. Anyone undergoing adjusting or manipulative procedures should know of possible complications which have been alleged. These include, but are not limited to, fractures, disc injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had an opportunity to ask questions about its contents, and by signing below, acknowledge my understanding of its contents.

_____
Date:

_____
Patient Name:

_____
Patient Signature:

_____
Relationship or authority
if not signed by patient:

DOCTOR'S NOTES

Patient counseled by the use of the following:

_____ Discussion

_____ Other (Please Specify)

_____
Signature of Doctor or Other

## Patient Information

Date _____

Patient _____

Address _____

_____

Sex ❑ M ❑ F Age _____ Birth Date _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birth date _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

_____

## Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Company _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birth Date _____ SS# _____

Relationship to Patient _____

Insurance Company _____

Group # _____

**ASSIGNMENT AND RELEASE**

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

## Contact Information

Home _____ Work _____ Ext ____

Cell _____ Email _____

Best time and place to reach you _____

**IN CASE OF EMERGENCY, CONTACT**

Name _____ Relationship _____

Home Phone _____ Work Phone _____

## Accident Information

Is condition due to an accident? ❑ Yes ❑ No Date____

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Work Comp. ❑ Other

Attorney's Name (if applicable) _____

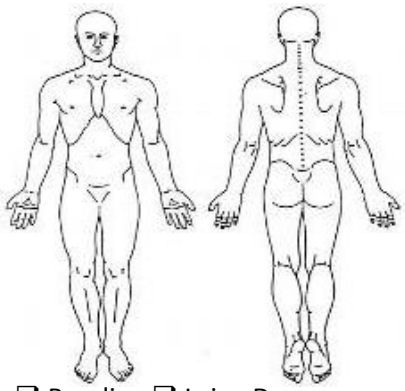
## Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition progressively getting worse? ❑ Yes ❑ No ❑ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 0 (No pain) to 10 (Worst pain) _____

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting

❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

## Health History

Medical doctor _____

What treatment have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy

❑ Chiropractic Services ❑ None ❑ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV | ❑ Yes ❑ No | Emphysema | ❑ Yes ❑ No | Miscarriage | ❑ Yes ❑ No | Scarlet Fever | ❑ Yes ❑ No |
| Alcoholism | ❑ Yes ❑ No | Epilepsy | ❑ Yes ❑ No | Mononucleosis | ❑ Yes ❑ No | Stroke | ❑ Yes ❑ No |
| Allergy Shots | ❑ Yes ❑ No | Fractures | ❑ Yes ❑ No | Multiple | | Suicide | |
| Anemia | ❑ Yes ❑ No | Glaucoma | ❑ Yes ❑ No | Sclerosis | ❑ Yes ❑ No | Attempt | ❑ Yes ❑ No |
| Anorexia | ❑ Yes ❑ No | Goiter | ❑ Yes ❑ No | Mumps | ❑ Yes ❑ No | Thyroid | |
| Appendicitis | ❑ Yes ❑ No | Gonorrhea | ❑ Yes ❑ No | Osteoporosis | ❑ Yes ❑ No | Problems | ❑ Yes ❑ No |
| Arthritis | ❑ Yes ❑ No | Gout | ❑ Yes ❑ No | Pacemaker | ❑ Yes ❑ No | Tonsilitis | ❑ Yes ❑ No |
| Asthma | ❑ Yes ❑ No | Heart Disease | ❑ Yes ❑ No | Parkinson's | | Tuberculosis | ❑ Yes ❑ No |
| Bleeding | | Hepatitis | ❑ Yes ❑ No | Disease | ❑ Yes ❑ No | Tumors, | |
| Disorders | ❑ Yes ❑ No | Hernia | ❑ Yes ❑ No | Pinched Nerve | ❑ Yes ❑ No | Growths | ❑ Yes ❑ No |
| Breast Lump | ❑ Yes ❑ No | Herniated Disc | ❑ Yes ❑ No | Pneumonia | ❑ Yes ❑ No | Typhoid Fever | ❑ Yes ❑ No |
| Bronchitis | ❑ Yes ❑ No | Herpes | ❑ Yes ❑ No | Polio | ❑ Yes ❑ No | Ulcers | ❑ Yes ❑ No |
| Bulimia | ❑ Yes ❑ No | High | | Prostate | | Vaginal | |
| Cancer | ❑ Yes ❑ No | Cholesterol | ❑ Yes ❑ No | Problem | ❑ Yes ❑ No | Infections | ❑ Yes ❑ No |
| Cataracts | ❑ Yes ❑ No | Kidney Disease | ❑ Yes ❑ No | Prosthesis | ❑ Yes ❑ No | Venereal | |
| Chemical | | Liver Disease | ❑ Yes ❑ No | Psychiatric Care | ❑ Yes ❑ No | Disease | ❑ Yes ❑ No |
| Dependency | ❑ Yes ❑ No | Measles | ❑ Yes ❑ No | Rheumatoid | | Whooping | |
| Chicken Pox | ❑ Yes ❑ No | Migraine | | Arthritis | ❑ Yes ❑ No | Cough | ❑ Yes ❑ No |
| Diabetes | ❑ Yes ❑ No | Headaches | ❑ Yes ❑ No | Rheumatic Fever | ❑ Yes ❑ No | Other _____ | |

| **Exercise** | **Work Activity** | **Habits** | |
|---|---|---|---|
| ❑ None | ❑ Sitting | ❑ Smoking | Packs/Day _____ |
| ❑ Moderate | ❑ Standing | ❑ Alcohol | Drinks/Week _____ |
| ❑ Daily | ❑ Light Labor | ❑ Coffee/Caffeine | Cups/Day _____ |
| ❑ Heavy | ❑ Heavy Labor | ❑ High Stress | Reason _____ |

Are you pregnant? ❑ Yes ❑ No Due date _____

| Injuries/Surgeries you have had | Description | Date |
|---|---|---|
| Falls | _____ | _____ |
| Head Injuries | _____ | _____ |
| Broken Bones | _____ | _____ |
| Dislocations | _____ | _____ |
| Surgeries | _____ | _____ |

| **Medications** | **Allergies** | **Vitamins/Herbs/Minerals** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| Pharmacy Name _____ | _____ | _____ |
| Pharmacy Phone _____ | _____ | _____ |