AMERICAN FAMILY SPINE & HEALTH LLC
3630 Poplar Tent Rd. Concord, NC 28027 • 704-792-2700

Patient Introduction

Please answer ALL questions

1. NAME: _____ 2. PHONE: _____

3a. ADDRESS: (include city, state and zip) _____

_____

3 b. E-MAIL ADDRESS: _____

4. DATE of BIRTH: _____ 5. AGE: _____ 6. NO. of CHILDREN: 7. OCCUPATION: _____

8. ( ) MALE ( ) FEMALE 9. ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOW

10. SPOUSE'S NAME: _____

11. NAMES AND AGES OF CHILDREN: _____

12. SS# _____ 13. EMPLOYERS' NAME: _____

14. WORK ADDRESS: _____ 15. WORK PHONE: _____

16. REFERRED BY: _____ 17. DO YOU HAVE INSURANCE?: *Yes* *No*

18. HAVE YOU HAD CHIROPRACTIC CARE BEFORE?: *Yes* *No*

19. IF SO, WHERE: _____

20. WHAT IS YOUR REASON FOR CONSULTING THIS OFFICE? _____

21. ARE YOU HERE BECAUSE OF: ( ) AUTO ACCIDENT ( ) JOB INJURY ( ) OTHER

22. DATE OF INJURY: _____ 23. ATTORNEY: _____

24. NAME OF INSURANCE COMPANY: _____ 25. CLAIM NO: _____

(please furnrsh front desk with your insurance card)

26. MEDICARE: *Yes* *No* POLICY # _____

27. MEDICAID: *Yes* *No* POLICY # _____

28. HAVE YOU HAD ANY FALLS, INJURIES OR AUTO ACCIDENTS? *Yes* *No*

IF YES, PLEASE DESCRIBE: _____

_____

29. HAVE YOU EVER HAD SURGERY? *Yes* *No*

IF YES, PLEASE DESCRIBE: _____

_____

30. ARE YOU PRESENTLY TAKING ANY MEDICATIONS? *Yes* *No*

IF YES, PLEASE LIST: _____

_____

Please *Circle* any of the following that give you difficulty

Headaches	Dizziness	Chest Pain	Numbness
Shooting Head Pains	Fainting	Mid-back Pain	Constipation
Sinus Trouble	Loss of balance	Heart attacks	Kidney trouble
Loss of smell	Ringing in ears	High blood pressure	Menstrual cramps & pain
Allergies	Blurred vision	Low blood pressure	Menstrual irregularity
Hay fever	Lights bother eyes	Anemia	Diabetes
Asthma	Neck pain	Stomach trouble	Cancer
Loss of taste	Muscle spasms in neck	Nerve and nervousness	Sleeping problem
Tightness of throat	Grating in neck	Inner tension	Painful joints
Throat inflammation	Tightness of shoulder muscles	Irritability	Swollen joints
Thyroid trouble	Pin in shoulder and arms	Cold sweats	Pinched nerves in back
Twitching of face	Pins & needles in arms & hands	Gall bladder trouble	Pins & needles in legs
Loss of memory	Cold hands	Indigestion	Swollen ankles
Fatigue	Intestinal gas	Cold feet	Pins in legs & feet
Depression	Shortness of Breath	Low back pain	

Insurance Information:
I understand that A.F.S.H will prepare any necessary forms to assist me in submitting claims to my insurance provider and credit my account when payment is received. However, I clearly understand that all services rendered to me are charged to me and I am responsible for payment unless other arrangements are made.

Patient / Guardian Signature _____ Date _____

If Patient is a child - Information and release:

Pregnancy Normal? *Yes - No* Explain: _____
Complications: _____

Delivery: Home ( ) Hospital ( ) List any complications: _____

Medications during delivery: _____
Vaccinations (List those received and age) _____

List any surgeries and or congenital conditions: _____

Childhood Diseases: Chicken Pox ( ) Measles ( ) Mumps ( ) Rubella ( ) Whooping Cough ( )
Ear infections ( ) How often? _____
Other: _____

Please Circle:
Asthma Headache Ear Infection Colic Allergies Bed Wetting

I hearby authorize A.F.S.H. and whomever they may designate to administer care as they deem necessary to my son/daughter/ward.

Patient/Guardian signature _____ Date _____

AMERICAN FAMILY SPINE & HEALTH LLC
3630 Poplar Tent Rd. Concord, NC 28027 • 704-792-2700

Authorization to Perform x-rays

This is to acknowledge that AFS&H has recommended that x-rays be taken so that a complete study and analysis may be made of my present condition.

Therefore, AFS&H is hereby authorized and directed to complete a radiographic examination in order to treat my present problem.

To the best of my knowledge I am not pregnant and AFS&H has my permission to x-ray me for diagnostic interpretation.

Date: _____

Signed: _____

Witness: _____

Consent for treatment

I give consent for AFS&H to administer whatever treatment is deemed necessary to treat my problem.

Date: _____

Signed: _____

Witness: _____

AMERICAN FAMILY SPINE & HEALTH LLC
3630 Poplar Tent Rd. Concord, NC 28027 • 704-792-2700

Patient and Doctor Agreement

I understand and agree that health and accident insurance are an arrangement between and insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare all necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services rendered to me on a pay-per visit basis will be immediately due and payable.

I herby authorize the doctor to treat my condition as the Doctor deems appropriate through adjusting my spinal column, I understand and agree that the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen by me at any time while I am a patient of this office. The x-ray negatives may be purchased from American Family Spine and Health, should I desire to do so. I also agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any preexisting medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature:

x _____ Date _____

Guardian of Spouse's Signature:

_____ _____

AMERICAN FAMILY SPINE & HEALTH LLC
3630 Poplar Tent Rd. Concord, NC 28027 • 704-792-2700

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care; American Family Spine and Health LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I understand and have heen provided with a Notice of Privacy Practices For Protected Health Information that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent,
The right to object to the use of my health information for directory purposes, and
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations .

I understand that American Family Spine and Health LLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that American Family Spine and Health LLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should American Family Spine and Health LLC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

_____

I understand that as part of this organization's treatment, payment, or, health care operations, it may become necessary to disclose my protected health information, to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept / decline the terms of this consent.

Patient's Signature _____

Date _____

FOR OFFICE USE ONLY
[ ] Consent received by on
[ ] Consent refused by patient, and treatment refused, aspermitted.
[ ] Consent added to the patient's medical record on

AMERICAN FAMILY SPINE & HEALTH LLC

3630 Poplar Tent Rd. Concord, NC 28027 • 704-792-2700

Patient's Name: _____

Patient's SS#: _____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES AMERICAN FAMILY SPINE AND HEALTH LLC (AFS&H) TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

_____ I give permission to AFS&H to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information.

_____ If AFS&H contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

_____ I give AFS&H permission to disclose protected health information in the presence of anyone accompanying me into a treatment room or consultation room by my request.

(OPEN ROOM AUTHORIZATION - OPTIONAL)

_____ I give AFS&H permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the Doctor at any time in private, the Doctor will provide a room for these conversations.

_____ If I am being referred to AFS&H, I furthermore understand the honor and trust involved on all levels. I agree that you may share any of my progress and evaluations with the person who referred me.

_____ By signing this form you are giving AFS&H permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION: The authorization shall expire on the following date: _____

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of AFS&H. *The written notice must contain the following information: your name, SS# and date of birth: a clear statement of your intent to revoke this AUTHORIZATION: the date of your request: and your signature.*

This revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by AFS&H for its own use/disclosure of PHI (minimum necessary standards apply).

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, AFS&H will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

*** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU***

Print Name of Patient: _____

Signature of Patient: _____

Date: Signature of Personal Representative: _____

Description of Representative's Authority to Act or Patient: _____