PURE CHIROPRACTIC
Restore your Power, Restore your Life!

Lake Oconee Office:
121 Harmony Crossing, Suite 6, Eatonton, Georgia 31024
p: 706.485.1010 f: 706.485.1019 e: info@pclakeoconee.com

Milledgeville Office:
130 Log Cabin Road, Suite B, Milledgeville, Georgia 31061
p: 478.457.0003 f: 478.457.0053 e: info@purechiropracticmilledgeville.com

HEALTH HISTORY PROFILE

Please fill out completely. All information is necessary.

Name: _____ M _____ F _____ Date _____

Address: _____ City _____ Zip _____

Phone: Home: _____ Cell: _____ Work: _____

Email address: _____

Birth Date: _____ Age: _____ Social Security Number: _____

Marital Status: M W D S Your Employer:_____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Children's Names and Ages:

_____

Who may we thank for referring you to our Center? _____

Method of Payment for First Visit: Cash Check Visa MasterCard

Insurance is NOT a requirement for our office, but do you have it? Yes _____ No _____

Current Health Complaints/reasons for consulting our office:

1. _____
2. _____
3. _____

Have you had the same or similar problem(s) before? Y N If so, for how long? _____

Have you seen a Chiropractor before? Y N If so, who? _____ When? _____

Is this the result of an auto or work injury? Y N If so, when? _____

Father, Mother, Brother, Sister, Children with similar problems? Y N If so, who? _____

Other Doctors you have seen for this problem: _____

Is there any chance you are pregnant? Y N

Have you ever been diagnosed with cancer? Y N If so, what kind? _____

How important is your health (1 not important, 10 extremely important) _____

If we discover a health problem, how important to you is correcting it? _____

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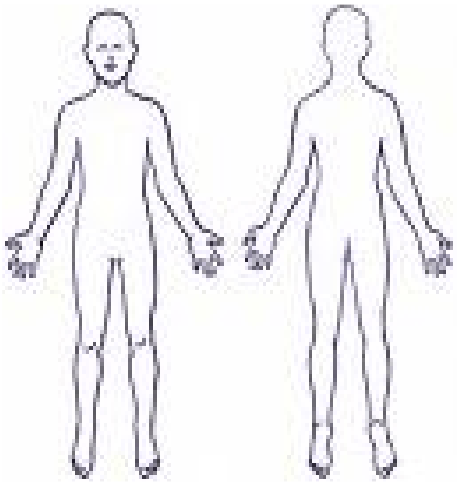
Please circle any areas of pain or discomfort.



Surgeries you've had:

_____

_____

Bones you've broken:

_____

_____

Medications you take (prescriptions, over-the-counter, Herbal remedies, supplements):

_____

_____

Check any health conditions you currently suffer from:

- ○ Headaches/migraines
- ○ Dizziness
- ○ Fatigue
- ○ Bronchitis
- ○ Diarrhea/constipation/IBS
- ○ Bladder problems
- ○ High cholesterol
- ○ Osteoporosis
- ○ Cancer—Type/Location

_____

- ○ Allergies/sinus problems
- ○ Depression
- ○ Asthma/wheezing
- ○ Heartburn/acid reflux
- ○ Gas/bloating
- ○ Prostate problems
- ○ Diabetes
- ○ Arthritis—Location

_____

- ○ Vision problems
- ○ Anxiety/high stress
- ○ Difficulty breathing
- ○ Indigestion
- ○ Kidney stone
- ○ PMS/post menopausal
- ○ High blood pressure
- ○ Other

_____

Traumas: By the time we reach adulthood, we've had dozens of impacts that cause subluxations.

Vehicle Accidents:

Date _____ Impact type: (rear, front, side) _____ Speed: _____mph

Date _____ Impact type: (rear, front, side) _____ Speed: _____mph

Work Related Injuries:

Date _____ Type _____

Date _____ Type _____

Sports—currently involved in, played in High School or College

Date _____ Sport _____ Injury _____

Date _____ Sport _____ Injury _____

Home—slips and falls, childhood injuries

Date _____ Type _____

Date _____ Type _____

The information on these two pages is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be able to obtain it. It will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health.

If during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____have read and fully understand the above statements.
(Print Name)

I understand the intent of Chiropractic care, based on the above, and consent to an examination, including X-rays if necessary. If my case is accepted, I also consent to Chiropractic adjustments, if these are deemed appropriate by the Doctors of Pure Chiropractic; I understand that adjustments may take place on a different day than my exam.

_____ _____
Signature Date

FINANCIAL POLICY

We are committed to providing you with the best chiropractic care possible. We have established our financial policies to achieve this goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless other arrangements are made in advance.

☑ Health Insurance: As your insurance policy is a contract between you and your insurance company, it is your responsibility for collection of these benefits. We will provide you with a statement, or "Superbill", which contains all the information necessary for your insurance company to reimburse you. These are given upon request. All you will need to do is mail it to your insurance company directly. If you provide a copy of your card, we perform a complimentary benefits check on your behalf.

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☑ Cash Patients: All fees are payable at the time services are rendered. There is no charge for a consultation in our office and all fees will be discussed with you before charges are incurred.

☑ Methods of Payment: For your convenience we accept Cash, Personal Checks or Credit Cards (Visa/MasterCard/Discover) for your initial visit. If a payment plan is chosen for future care, this is handled by auto collection through your Visa/MasterCard/Discover/EFT on file with our office. There is a $20 fee on all returned EFTs *or* paper checks, *and* a $5 fee on returned Visa/MasterCard/Discover transactions. Should you require a copy of your X-rays, there is a $50 copy fee and we require 5 business days to complete your request. We make the payment process as simple and smooth as possible, so you will have an enjoyable visit in our office.

I have read and understand the above policies.

_____ _____
Patient Signature (Parent or Legal Guardian) Date

PRIVACY NOTICE ACKNOWLEDGEMENT

We are concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the uses and limitation of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I, _____ **acknowledge that I have received a copy** of Pure Chiropractic's *Notice of Privacy Practices for Protected Health Information.*

_____ _____
Patient Signature Date

_____ _____
Personal Representative Printed Personal Representative Signature

Description of personal representative's authority to act for the patient:

_____

_____

_____

_____

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NOTICE OF PRIVACY FOR PROTECTED HEALTH INFORMATION

This notice Describes how Chiropractic and Medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Use and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1. Your chiropractor or a staff member may have to disclose your health information, including all of your clinical records, to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health.
2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3. Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4. Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.520(b)(I)(iii)(A). If you are not at home to receive the appointment reminder, a message will be left on your machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

Permitted Uses and Disclosures Without Your Consent or Authorization

Under Federal Law, we are also permitted or required to disclose your health information without your consent or authorization in the following circumstances:

1. If we are providing health care services to you based on the orders of another health care provider.
2. If we provide health care services to you as an inmate.
3. If we provide health care services to you in an emergency.
4. If we are required by law to treat you and were unable to obtain your consent after attempting to do so.
5. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples and noted in the uses and disclosures section above, other use or disclosure of your health information will only be made with your written authorization.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive request to revoke your authorization 164.508(b)(5)(i)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at our office address, c/o Billing Department.

Your Right to Limit Uses or Disclosures

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If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know in writing to what individuals or organizations you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your Right to Receive Confidential Communication Regarding Your Health Information

We normally provide information about your health to you in person at the time you receive services. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about health or the services that we provided at a place other than your home, or, if you would like information in a different form. To help us respond to your needs, please make any request in writing.

Your Right to Inspect and Copy Your Health Information

You have the right to request that we give you an account of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except these disclosures:

- Required for your treatment, to obtain payment for your services, or to run our practice
- Made to you or to individuals involved in your care
- Necessary to maintain a director of the individuals in our facility
- For national security or intelligence purposes, as required by law
- Made to correction officers or law enforcement officers, as required by law
- That were made prior to the effective date of the HIPPA privacy law
- We will provide the first accounting within a 12 month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request, we will tell you the amount of the fee, and you will have the opportunity to withdraw or modify your request. There is a $20 fee on all returned EFTs *or* paper checks, *and* a $5 fee on returned Visa/MasterCard/Discover transactions. Should you require a copy of your X-rays, there is a $50 copy fee and we require 5 business days to complete your request.

Your Right to Obtain a Paper Copy of This Notice

If you have agreed to the privacy notices by email, you may request a paper copy of this notice at any time.

Our Duties
We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement, we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms, the change will apply for all your health information in our files.

Re-Disclosure
Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by federal privacy rules.

Your Right To Complain
You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint, and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to Hannah Goss, Office Manager, at our office address shown at the top of the opposite page.

To Contact Us
If you would like further information about our privacy policies and practices, please contact Pure Chiropractic Lake Oconee at 120 Harmony Crossing, Suite 6,Eatonton, GA 31024 or by phone at 706-485-1010. This notice is effective as of May 14, 2003, or the date of your signed acknowledgement of receipt of this notice. This notice will expire six years after the date upon which the record was created.