RECOVERY CHIROMED

New Patient Registration for a Minor – PI (Slip & Fall)

How were you referred to this office? _____
If referred by an attorney, please specify which attorney: _____

Personal History

Patient's Name: _____
Home #: _____ Cell #: _____
Email: _____ Business #: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Sex: Male or Female
Social Security #: _____
Marital Status: Single Married Divorced Widowed Separated
Business/Employer: _____ Type of Work: _____
Emergency Contact's Name: _____
Relation: _____ Home Phone #: _____ Cell Phone#: _____

Current Health Condition

Major Complaints: _____
Your complaint is due to an: Auto Accident Work Injury Other Accident
Unknown Causes Other: _____
Have you had this problem before in the past? Yes or No If Yes, how long ago? _____
Date of Accident/Injury or Date your pain/problem began: _____
If disabled from work, please give dates: _____

Is your pain: Improving Getting Worse About the Same Comes & Goes

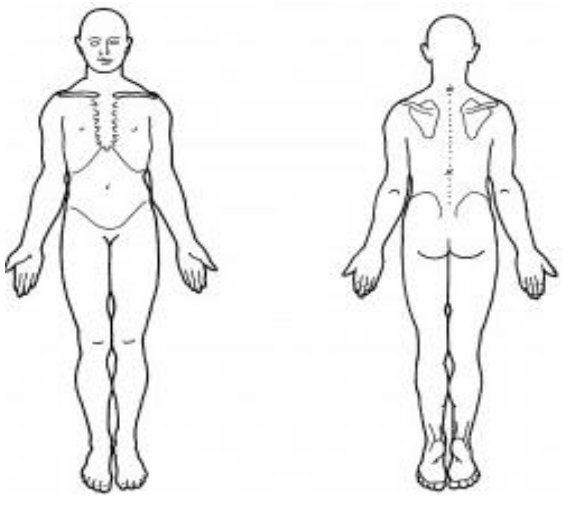
Circle any activity that aggravates your condition: Standing Sitting Walking Bending
Twisting Coughing Lying Lifting Other: _____

When is the pain/problem worse? Morning Noon Night
Does your pain awaken you at night? Yes or No
Have you been seen by another Doctor for this condition? Yes or No
If Yes, Doctor's Name: _____
Last date consulted/examined/treated: _____ Diagnosis: _____
Medication(s) you are taking presently: Nerve Pills Pain Meds Muscle Relaxers Insulin
Blood Pressure Pills Aspirin Tylenol Advil Vitamins Supplements
Other: _____
Name of Medical Provider: _____

Using the scale 0-10, with 0 being no pain and 10 being the worst possible pain, please indicate your present pain level:
_____

Please mark your area(s) of pain discomfort on the diagram to the right using the appropriate letter(s):

(B) Burning (N) Numb
(C) Cramping (S) Stabbing
(D) Dull (T) Tingling



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Past Health History

Major Accidents or Falls: _____
Major Surgeries/Operations: Heart Back Neck Leg Arm Hip Appendix Tonsils Hernia
Other: _____
Hospitalization(s) other than above: _____
Have you been treated for any other health condition in the last year? Yes or No
If Yes, please explain: _____
Does anyone in your family suffer from the same problem? Yes or No
If Yes, please list the relation: _____

Check any of the following diseases / conditions you have currently or had:

____Bed Wetting	____Multiple Sclerosis	____AIDS/HIV	____Gout
____Bladder Trouble	____Nervousness	____Alcoholism	____Hepatitis
____Bleeding Disorders	____Painful Urination	____Anemia	____Hernia
____Bowel Trouble	____Parkinson's Disease	____Anorexia	____Herpes
____Breast Pain	____Pinched Nerves	____Arthritis	____Irritability
____Chemical Dependency	____Pneumonia	____Asthma	____Measles
____Chicken Pox	____Prostate Dysfunction	____Bulimia	____Migraines
____Discolored Urine	____Psychiatric Care	____Cancer	____Mumps
____Heart Disease	____Rheumatic Fever	____Cataracts	____Pacemaker
____Herniated Disc	____Scarlet Fever	____Depression	____Sleep Loss
____High Cholesterol	____Sexual Dysfunction	____Diabetes	____Stress
____Kidney Disease	____Suicide Attempt	____Emphysema	____Stroke
____Liver Disease	____Typhoid Fever	____Epilepsy	____Thyroid
____Menstrual Cramps	____Vaginal Infection	____Fractures	____Tonsillitis
____Menstrual Irregularity	____Venereal Disease	____Glaucoma	____Tumors
____Mononucleosis	____Whooping Cough	____Gonorrhea	____Ulcers

Females Only: Are you pregnant? Yes or No If Yes, when is your due date? _____
If No, when was your last menstrual cycle? From_____ to _____

Do you exercise? Yes or No
If Yes, which would best describe your exercise intensity: Mild Moderate Strenuous
Do you smoke? Yes or No If Yes, how often? _____
Do you drink alcohol? Yes or No If Yes, how many drinks per week? _____
What does your work activity mainly consist of? Sitting Standing Light Labor Heavy Labor

I CERTIFY THAT THIS INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Patient's Signature: _____ Date: _____

Slip and Fall

Patient's Name: _____ Date of Accident: _____

Insurance Claim #: _____ Policy #: _____
Insurance Company: _____
Address: _____
Adjuster: _____ Phone #: _____

Responsible Insurance Claim #: _____
Policy #: _____
Insurance Company: _____
Address: _____
Adjuster: _____ Phone #: _____

Time of Accident: _____ AM / PM
Location of Accident: _____
In as much detail as possible, please describe how your injuries occurred:

_____

_____

_____

_____

Could you move all parts of your body after the accident? □ Yes □ No
If No, what parts couldn't you move and why? _____
Were you able to walk unaided following the accident? □ Yes □ No
If No, why? _____
Did you get any bruises? □ Yes □ No
If Yes, where? _____
Did you have any bleeding cuts? □ Yes □ No
If Yes, where? _____

Please describe how you felt:

Immediately after the accident: _____

Later that day: _____

The next day: _____

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Check symptoms that have appeared since the accident:

__ Foot/ Ankle Pn Lt / Rt	__ Upper Arm Lt/ Rt	__ Migraines
__ Lower Leg Pn Lt/ Rt	__ Shoulder Pn Lt/ Rt	__ Dizziness/ Vertigo
__ Knee Pn Lt/ Rt	__ Lumbar Pain	__ Light Headed
__Thigh Pn Lt/ Rt	__ Thoracic Pain	__ Anxiety
__ Hip Pn Lt/ Rt	__ Paresthesia LE	__ Depression
__ Hand Pn Lt/Rt	__ Paresthesia UE	__ Irritability
__ Wrist Pn Lt/ Rt	__ Neck Pain	__ Jaw Popping/ Clicking
__ Lower Arm Pn Lt/ Rt	__ Non Migraine Headaches	__ Tinnitus

Did you seek medical help immediately after the accident? □ Yes □ No

If Yes, how did you get there? □ someone else took me □ police □ ambulance

□ drove my own car □ other: _____

Doctor's Name: _____

Practice Name & Address: _____

Were X-rays taken? □ Yes □ No

Did you receive: □ collar □ brace (s) □ medication (s) □ Other:_____

If Yes to medication (s), what did you receive? _____

What benefits did you receive from the treatment? _____

Date of last treatment? _____

Do you have an attorney for this claim? □ Yes □ No

If Yes, who? _____

Address: _____

City: _____ State: ___ Zip: _____ Phone: _____

Patient's Signature: _____ Date: _____

Patient's Name Printed: _____

RECOVERY CHIROMED

Office Policy

Patient's Name: _____

Thank you for choosing us as your health care provider. Please understand that payment of your bill is considered part of your treatment. The following statements refer to our office policies, which we require you read, accept, sign and date before any treatment can begin.

- Every new patient is required to fill out forms concerning his/her history and general information prior to being examined.
- Each insurance company or group has specific guidelines that we must follow to warrant payments for our services. As a courtesy to you, we file all claims to your insurance company or group. Please remember that YOU have to contract with the insurance company or group and YOU are ultimately responsible for payment. We cannot accept responsibility for collecting from your insurance company or group, nor negotiating a settlement on a dispute of a claim. If you need assistance with your insurance, please see our office manager, who will readily assist you.
- Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary of our area. Please understand that you are responsible for payment in full regardless of an insurance company's arbitrary determination of usual and customary rates.
- Open accounts with no ACCEPTABLE payment activity for 60 days will be considered past due. A billing charge may be assessed to the account balance along with a finance charge of 1.5% per month. You will be responsible for the original past due balance along with these additional charges. ACCEPTABLE payment activity will be determined on an individual basis. Please speak with our office manager to avoid any misunderstandings.
- Open accounts with no ACCEPTABLE payment activity for 120 days will automatically be placed with our collection agency. You will be responsible for payment of the original balance plus any billing charges, finance charges, collection fees and attorney fees assessed to your account.

The adult accompanying a minor is responsible for full payment. The adult (i.e. parent or legal guardian) must be present with the minor and sign the treatment consent form before any services can be administered.

Patient's Signature: _____ Date: _____

I authorize Recovery ChiroMed to release medical records, radiographs and reports to any physicians, other health care providers, or insurance companies/groups that may be consulted or who need direct access to these records for health care.

Patient's Signature: _____ Date: _____

Informed Consent Form

Every type of health care is associated with some risk of potential problems. Health care providers including chiropractors are required by law to tell you the nature of your condition, the general nature of the treatment, and the risks involved. In keeping with the Louisiana Law of Informed Consent, you are being asked to sign and date this form which confirms our discussion of these matters.

We want to give each patient the best possible care with the least possible risk of complications. To accomplish this, we format treatment plans to suit the distinctive needs of each patient. The following paragraphs describe the most severe risks associated with chiropractic care which are extremely rare in occurrence:

- **STROKE**: Stroke is the most serious problem associated with spinal manipulation. The consequences can be temporary or permanent dysfunction of the brain with very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery which runs on each side of your neck. This problem occurs so rarely that there is no conclusive data that specifies quantity of probability.
- **DISC HERNIATION AGGRAVATION:** Disc herniations that create pressure on the spinal nerve and/or spinal cord are successfully treated by chiropractors on a daily basis. Chiropractic manipulation can aggravate an existing disc herniation resulting in an increase of symptoms which may last for a few days but seldom for longer periods of time.
- **SOFT TISSUE INJURY:** Soft tissue primarily refers to muscles and ligaments. Muscles move bone, and ligaments limit bone movement. Rarely, chiropractic manipulation can result in minor damage to a particular soft tissue. This may cause a temporary increase in pain and necessary treatments for resolution, but there are no long term effects to the patient.
- **RIB FRACTURES:** The rib cage is found in the thoracic spine or middle back area. Rarely does chiropractic manipulation cause a fracture of a rib to occur. Patients who have weakened bones (Osteopenia or Osteoporosis) have a higher risk of rib fractures because their bones are weaker than normal. We adjust all patients carefully, especially those who have indications of osteoporosis on their X-rays.
- **OTHER POSSIBLE COMPLICATIONS:** There are many other side effects and/or complications that may also rarely occur due to spinal manipulation. These possible complications include, but are not limited to the following: headaches, skin burns, dizziness, radiating pains into the arms and/or legs, exacerbation of pain/problem, soreness, etc.

I hereby authorize any Recovery ChiroMed Practioner to provide chiropractic treatments including examination/diagnostic, spinal manipulation/adjustments, and various modes of physical therapy that may be deemed necessary or responsible. My treatment plan will be explained to me and I have read and I understand all information set forth in this document, including any attachments. I acknowledge that I will have the opportunity to ask any questions about the contemplated procedure and that my questions will be answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

Patient's Name Printed: _____

Patient's Signature: _____ Date: _____

I certify that I have provided and explained the information set forth herein, including any attachments and have answered all questions concerning proposed treatment to the best of my knowledge and ability.

_____ _____

Recovery ChiroMed Practioner Date

RECOVERY CHIROMED

Treatment Consent Form for a Minor

I,_____,
hereby authorize any Recovery ChiroMed Practioner to administer chiropractic care as he/she deems necessary to my son/daughter/other.

Name of Minor: _____ Date: _____

Parent/Guardian: _____
(Printed Name)

Parent/Guardian: _____
(Signature)

Witness Signature: _____

RECOVERY CHIROMED

Notice of Privacy Practices for Protected Health Information Page 1

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 it carefully.

Uses and Discloses

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

- 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 condition.
- Our insurance of billing staff may have to disclose your examination and treatment records and your billing records to another party, such as insurance carrier, and HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
- Our chiropractor and members of the practice 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.
- 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) (1) (iii) (A). If you are not at home to receive an appointment reminder, a message will be left on your answering 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 authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

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 use or disclose your health information without your consent or authorization in these following circumstances:

- We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
- We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
- We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
- We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
- We are permitted to use or disclose your health information 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 examples, any 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:

- If we have already released your health information before we received your request to revoke your authorization 164.508(b)(5)(i).
- If you were required to give 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:

Recovery ChiroMed
P.O. Box 698
Luling, LA 70070

Your Right to Limit Uses or Disclosures

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 what individuals or organizations to whom 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 chiropractic services from us. 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 your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to our needs, please make any request in writing.

Notice of Privacy Practices for Protected Health Information Page 2

Your Right to Inspect and Copy Your Health Information
You have the right to inspect and/or copy your health information for six years from the date that the record was created or as long as the information remains in our files.

Your Right to Amend Your Health Information
You have the right to request that we amend your health information for six years from the date that the record was created or as long as the information remains in the files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your Right to Receive an Accounting of the Disclosures we Have Made of Your Records
Louisiana law requires that we furnish you, upon your request, a copy of any information related in any way to you which we have transmitted to any company, or public or private agency, or any person.

We may charge reasonable copying charges for this service which are set forth in the statues as well as a handling charge and actual postage.

We may deny access to a record if we reasonably conclude that knowledge of the information contained in the record would be injurious to the health or welfare of the patient or could reasonably be expected to endanger the life or safety of any other person.

Your Right to Obtain a Paper Copy of This Notice
If you have agreed to receive 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 to all of 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 the federal privacy rules.

Your Right to Complain
You may complain to us or to the Secretary for 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:

Recovery ChiroMed
P. O. Box 698
Luling, LA 70070

If you would like further information about our privacy policies and practices, please contact:

Recovery ChiroMed
P.O. Box 698
Luling, LA 70070
985-331-8007

This notice is effective as of APRIL 1, 2003. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

_____ _____
Patient's Name Printed Date

_____ _____
Patient's Signature Recovery ChiroMed Authorized Provider Representative

_____ _____
Personal Representative's Name Printed Personal Representative's Signature

_____
Description of Personal Representative's Authority to act for the Patient

RECOVERY CHIROMED

Controlled Substance Prescription Responsibility Agreement

Prior to writing a script for controlled substances to a patient, our clinic requires the patient's agreement to following terms below. Please initial next to each term. Failure to adhere to this agreement will result in the discontinuation of medication.

- _____ I agree to store medication properly. Medication may be harmful to children, household members, guests or pets and should be stored in a safe place. If anyone besides the patient ingests the medication, the patient must immediately call 911 or the poison control center. These medications may not be resold.

- _____ I agree to take the medication only as prescribed. I will not make any dosage modifications without prior discussion with this clinic's physician. Dosage modifications will be determined on a case by case basis.

- _____ I agree to notify the doctor's office immediately in the case of lost or stolen medication. I will file a police report and bring a copy to the clinic for their record. Replacement scripts will be determined on a case by case basis.

- _____ I will not take other controlled substances, PRESCRIBED OR NONPRESCRIBED, without disclosing it to this clinic's medical doctor. I understand that not fully disclosing all medications may result in discharge from this clinic. I will discuss and notify this clinic's physician if another doctor I am treating under changes my medication dosage. Violation of this agreement is unlawful and may result in criminal prosecution.

Patient's Signature: _____ Date: _____

Patient's Name Printed: _____

Witness: _____ Date: _____

Insurance Information

Medical Insurance:

Do you have medical insurance? Yes or No

If so, Provider: _____

Member ID Number: _____

Auto Insurance:

Patient Auto Ins. Co: _____

Adjuster: _____ Phone#: _____

Claim #: _____

Do you have Medpay Coverage? Yes or No

At Fault Driver: _____

Auto Ins. Co.: _____

Adjuster: _____ Phone#: _____

Claim #: _____

Attorney Information if being Represented:

Attorney: _____

Phone#: _____

Address: _____

Authorization For Release of Records
Luling Clinic

Date: _____

Recovery ChiroMed
12501 Highway 90
Luling, LA 70070

Phone #: 985-331-8007
Fax #: 985-331-8003
To: _____

Patient: _____
Date of Birth: _____
Social Security #: _____

Our clinic is requesting the following records:

___ Medical Records ___ CT Scan Reports

___ X-ray Reports ___ Lab Reports

___ MRI Reports ___ Other

Thank you in advance,
Recovery ChiroMed

Patient's Signature/Firma de Paciente: _____

Date/Fecha: _____

RECOVERY CHIROMED

Billing and Payment

_____ **Self-pay**: If you have no available insurance coverage, you will be billed directly for services provided at the time services are rendered.

_____ **Health Insurance**: We will bill your health insurance provider if, at the time of service, we are a contracted provider with the insurance company. However, you must remit all payments due as a result of any deductible, co-insurance, and/or co-payments per the insurance plan. These payments as well as payments for services not covered under the plan are due at the time each service is rendered.

_____ **Third Party Fault**: In the event that a third-party is at fault for your injury and you wish for us to bill that third-party or your auto insurance medical payments carrier instead of your health insurer, then we will attempt to collect from the third-party at the full cost of our services. However, in the event that the third-party recovery is unsuccessful, then you will be responsible for the full amount of the outstanding medical bill.

Patient's Signature: _____ Date: _____

Patient's Name Printed: _____

Patient's Representative (if minor): _____

Relationship to Patient: _____

Name of Attorney if represented: _____