

Chiropractic Registration and History



Patient Information

Date: _____
SS#: _____
Patient Name: _____
Address: _____
Suite / Apt#: _____
City: _____
State: _____ Zip: _____
Email: _____
Home Phone Number: _____
Cell Phone Number: _____

Date of Birth: _____
Sex: Male Female

Occupation: _____
Employer: _____
Employer Phone: _____

Spouse's Name: _____
Date of Birth: _____

Whom may we thank for referring you? _____

In case of Emergency, contact:

Name: _____
Relationship: _____
Phone Number: _____

Accident Information

Is your condition due to an accident: Yes No
Date of Accident: _____
Type: Auto _____ Work _____ Home _____ Other _____
To whom have you made a report of your accident?
_____ Auto Ins. _____ Employer _____ Work Comp.
Attorney Name: _____

*Please find additional documents under patient forms to complete if this is a result of an auto accident.

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. French all insurance benefits, if any, otherwise payable to me for my services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

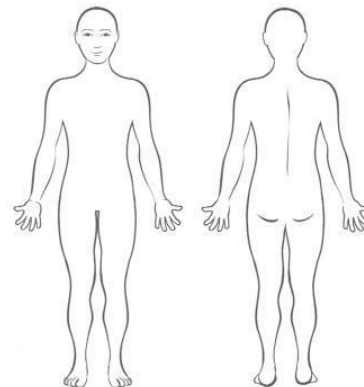
The above-named doctor may use my health care information and may disclose such information to the above name Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for relating services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature: _____
Print Name: _____
Date: _____
Relationship to Patient: _____

Patient Condition:

Reason for Visit: _____
When did your symptoms appear? _____

Is this condition getting progressively worse: Yes No
Mark an **X** on the picture below where you continue to have pain, numbness, or tingling.



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Patient Condition Continued:

Rate the severity of your pain on a scale from 1 (least pain) to 10 (Sever pain). _____

Type of pain: (Circle all that apply)

Sharp	Dull	Throbbing
Aching	Shooting	Numbness
Burning	Tingling	Cramps
Stiffness	Swelling	Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does the pain interfere with your:

Work - Sleep - Daily Routine - Recreation

Activities or movements that are painful to perform:

Sitting – Standing – Walking – Bending – Lying Down

Health History

What treatments have you already received for your condition? Medication – Surgery – Physical Therapy

Name of Doctors who have treated you for your condition? _____

Date of last: Physical Exam: _____
Spinal X-Ray: _____
Blood Test: _____
Dental X-Ray: _____
MRI, CT, Bone Scan: _____

Exercise:

_____ None
_____ Moderate
_____ Daily
_____ Heavy

Work Activity:

_____ Sitting
_____ Standing
_____ Light Labor
_____ Heavy Labor

Habits:

_____ Smoking Packs/Day _____
_____ Alcohol Drinks/Week _____
_____ Coffee/Caffeine Cups/Day _____
_____ High Stress Level Reason _____

Are you pregnant? Yes No Due Date: _____

Please check to indicate if you have had any of the following:

_____ AIDS/HIV	_____ Alcoholism
_____ Allergy Shots	_____ Anemia
_____ Anorexia	_____ Appendicitis
_____ Asthma	_____ Bleeding Disorder
_____ Breast Lump	_____ Bronchitis
_____ Breast Implants	_____ Bulimia
_____ Cancer	_____ Cataracts
_____ Chicken Pox	_____ Diabetes
_____ Emphysema	_____ Epilepsy
_____ Fractures	_____ Glaucoma
_____ Gout	_____ Heart Disease
_____ Hepatitis	_____ Hernia
_____ High Blood	_____ High Cholesterol
_____ Pressure	_____ Migraine / Headaches
_____ Measles	_____ Liver Disease
_____ Miscarriages	_____ Mononucleosis
_____ Mumps	_____ Multiple Sclerosis
_____ Osteoporosis	_____ Pacemaker
_____ Pinched Nerve	_____ Parkinson's disease
_____ Pneumonia	_____ Polio
_____ Prosthesis	_____ Prostate Problem
_____ Scarlet Fever	_____ Psychiatric Care
_____ Stroke	_____ Rheumatic Fever
_____ Tuberculosis	_____ Suicide Attempt
_____ Tonsillitis	_____ Thyroid Problems
_____ Ulcers	_____ Tumor, Growths
_____ Typhoid Problems	_____ Herniated Disk
_____ Vaginal Infections	_____ Whooping Cough
_____ Kidney Disorder	_____ Rheumatoid Arthritis
_____ Chemical Dependency	
_____ Sexually Transmitted Disease	
_____ Other: _____	

Injuries/Surgeries you have had: _____

Falls: _____ Broken Bones: _____

Head Injury: _____ Dislocations: _____

Surgeries: _____

Medications: _____

Allergies: _____

Vitamins/Herbs/Minerals: _____

A. Notifier: Back in Motion, Dr. Kenneth French & Dr. Tammy French

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D. Chiropractic Treatments	E. Reason Medicare May Not Pay:	F. Estimated Cost
Examination, Spinal Manipulation, Electrical Stimulation, Interferential Therapy, X-Rays and other Chiropractic services.	Medicare may deem services are not medically necessary for your condition, you may have exclusions on your plan that do not cover Chiropractic. Capitalization plans and HMO plans do not cover chiropractic care.	\$125 - \$200

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

OPTION 1. I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

OPTION 3. I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:

J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

NOTICE of HMO or Capitation Plans

Do you know if your Medicare or Secondary is an **HMO** or **Capitation Plan**? If so, unfortunately they do not cover any chiropractic care or spinal manipulations and you will be billed for these services.

Please let us know if you are aware that your Medicare is an HMO or Capitation Plan so we can bill accordingly to save us time and you money.

Thank you,

Back in Motion

P.S. Feel free to visit the website below to understand your Medicare covered services for your Chiropractic care.

<http://www.medicare.gov/coverage/chiropractic-services.html>

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

Form 7 - NOTICE OF PRIVACY POLICY - French Chiropractic Center, PA d/b/a Back in Motion

Effective April 14th, 2003

The following is the notice of privacy policy ("Privacy Notice") of French Chiropractic Center, PA d/b/a Back in Motion ("Covered Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms of that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include: (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and that the use or disclosure complies with and is limited to the relevant requirements of such law.

Examples of instances in which we are required to disclose your personal health information include: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right to Request Restrictions on Use or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures:* to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right to Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right to Inspect and Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for:* (a) psychotherapy notes, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We require a written request. We must provide you with access to your personal health information in the electronic form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy

of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right to Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. *We have the right to deny your request for amendment, if:* (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services (“HHS”). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to: Tammy J. French, D.C., c/o French Chiropractic Center, PA d/b/a Back in Motion, 5695 Naples Blvd., Naples, FL 34109.

Right to Receive an Accounting of Disclosures of Your Personal Health Information

You have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes:* (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to: Tammy J. French, D.C., c/o French Chiropractic Center, PA d/b/a Back in Motion, 5695 Naples Blvd., Naples, FL 34109.

Complaints

You may file a complaint with us and with the Secretary of HHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy/security officer, Tammy J. French, D.C., c/o French Chiropractic Center, PA d/b/a Back in Motion, 5695 Naples Blvd., Naples, FL 34109.

A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this privacy policy. A complaint must be received by us or filed with the Secretary of HHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Fundraising Solicitation Policy

In the event that the practice elects to engage in fundraising activities, the patient will have the right to opt out of receiving communications about these fundraising activities. Any communication sent to the patient regarding fundraising will include instructions on how the patient may opt out.

Non-Covered Services

Patients have the right to restrict certain disclosures of PHI to their Health Plan where the individual or someone on his or her behalf pays out of pocket for the health care item or service provided.

Right to Notification upon Breach

Patients have a right to be notified following a breach of their unsecured PHI. In the event of a known breach of your PHI, we will notify you in writing of the breach, as well as filing a notice of the breach with the secretary of DHHS, as well as any other action that may be required by law.

Other Uses and Disclosure

All other uses and disclosures of PHI not described in this notice will be made only with the written authorization of the patient.

Amendments to this Privacy Policy

We reserve the right to revise or amend this privacy policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this privacy policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days after the effective date of such revision, amendment, or change.

Ongoing Access to Privacy Policy

We will provide you with a copy of the most recent version of this privacy policy at any time upon your written request sent to Tammy J. French, D.C., c/o French Chiropractic Center, PA d/b/a Back in Motion, 5695 Naples Blvd., Naples, FL 34109. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy/security officer Tammy J. French, D.C. at the address, telephone number, or e-mail address listed above.

French Chiropractic Center, PA d/b/a Back in Motion

Form 6 - PATIENT ACKNOWLEDGEMENT FORM NOTICE OF PRIVACY PRACTICES

I have been provided with a copy of French Chiropractic Center, PA d/b/a Back in Motion Notice of Privacy Practices, which describes French Chiropractic Center, PA d/b/a Back in Motion's use and disclosure of my Protected Health Information (PHI).

PATIENT NAME: _____ **DOB:** _____

SIGNATURE: _____ **DATE:** _____