

REGISTRATION

Date: _____

Phone: _____

Patient: _____
Last Name
First Name
Initial

Street Address: _____

City/State/Zip Code: _____

Sex: M F Age: ____ Birthdate: _____ Single Married Widowed Separated Divorced

Social Security #: _____ Email: _____

Insured's Name: _____
Last Name
First Name
Initial

Patient Agreement:

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to Anderson Spine and Injury Chiropractic Center all medical 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 my insurance submissions.

 Signature of Insured/Guardian

 Date

Present Complaints (Please circle the appropriate ones)

Headache
 Mental dullness
 Loss of memory
 Dizzy
 Ears ringing/buzzing
 Upper back pain
 Lower back pain
 Midback pain
 Pins and needles in hands
 right/left

Feet/Hands Cold
 Depression
 Rib pain
 Nervousness
 Eye strain/pain
 Shortness of breath
 Fear
 Confusion
 Pins and needles in arms
 right/left

Unbalanced
 Fainting
 Blurred vision
 Irritability
 Double vision
 Loss of smell
 Chest pain
 Neck pain
 Pins and needles in legs
 right/left

Medical Implants: _____

Medical alerts: _____

Surgical Implants: _____

Pregnancy: yes ____ no ____

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain
----------------	---	---	---	---	---	---	---	---	---	---	----	--------------------------

Patient Name: _____

Date: _____

Medications: *(please list all medications and supplements that you currently take)*

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: *(please list all medications that cause allergic reaction)*

_____	_____	_____
_____	_____	_____
_____	_____	_____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____	Date _____
_____	_____
_____	_____
_____	_____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

NO MEDICAL PROBLEMS - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> pulmonary embolism | <input type="checkbox"/> respiratory arrest |
| <input type="checkbox"/> COPD | <input type="checkbox"/> pneumonia | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> other: _____ |

Cardiac / Heart and peripheral vascular disease

- | | | |
|---|---|--|
| <input type="checkbox"/> chest pain / angina | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> irregular heartbeat, arrhythmia |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> heart murmur, valve disorder | <input type="checkbox"/> peripheral vascular disease |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> deep vein thrombosis |
| <input type="checkbox"/> other: _____ | <input type="checkbox"/> bleeding problems | |

Neurologic Disorders

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> stroke or TIA | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> cerebral palsy |
| <input type="checkbox"/> peripheral neuropathy | <input type="checkbox"/> MS | <input type="checkbox"/> polio |
| <input type="checkbox"/> other: _____ | | |

Bone & Joint Disorders

- | | | |
|---|--------------------------------|---|
| <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> gout | <input type="checkbox"/> osteomyelitis |
| <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> lupus | <input type="checkbox"/> ankylosing spondylitis |
| <input type="checkbox"/> other: _____ | | |

Patient Name: _____ Date: _____

Gastrointestinal Disorders

- peptic ulcer or stomach ulcer
- acid reflux, GERD
- GI bleed
- other: _____
- diverticulitis
- irritable bowel
- inflammatory bowel disease
- hepatitis - Type _____
- liver disease

Genitourinary Disorders

- urinary tract infection
- bladder problems
- kidney problems
- kidney stones
- dialysis, kidney failure
- other: _____

Metabolic & Other Disorders

- Diabetes x _____ years
- thyroid problems
- sickle cell disease
- high cholesterol or lipids
- skin disorder _____
- psoriasis
- any skin ulcer
- tooth abscess, gingivitis
- depression
- anxiety
- alcohol or drug dependency
- other: _____

Cancer : any type -- please specify

Other medical problems NOT included above (explain)

Family History:

Please indicate with an "X" any significant family medical history or problems.

- asthma
- COPD or Emphysema
- heart attack, myocardial infarction
- irregular heartbeat, arrhythmia
- MS or Parkinson's
- osteoarthritis
- rheumatoid arthritis
- acid reflux, GERD
- liver disease
- kidney problems
- diabetes
- thyroid problems
- Malignant hyperthermia
- tuberculosis
- other lung : _____
- congestive heart failure
- bleeding problems
- Peripheral neuropathy
- other neuro : _____
- Lupus
- Other bone & joint: _____
- inflammatory bowel disease
- other GI : _____
- dialysis, kidney failure
- psoriasis
- sickle cell disease
- any skin ulcer
- sleep apnea
- hepatitis - Type _____
- high cholesterol or lipids
- any skin ulcer

Cancer : any type -- please specify

Other medical problems NOT included above (explain)

Patient Name: _____

Date: _____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Blue Shield | <input type="checkbox"/> Auto Accident |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Major Medical | <input type="checkbox"/> Union Plan |
| <input type="checkbox"/> Blue Cross | <input type="checkbox"/> Worker's
Compensation | <input type="checkbox"/> Other |

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

Major Medical or Auto Insurance:

Date of Accident: _____

Insurance Company Name: _____

Adjuster: _____

Address/Phone: _____

Claim #: _____ Policy #: _____ Effective Date: _____

Primary Care Physician:

Name & Address: _____

Phone #: _____

LEGAL INFORMATION:

Attorney Name & Address: _____

Attorney Phone #: _____

*Person to contact in an emergency (Name and Phone #): _____

Patient Name: _____ Date: _____

MOTOR VEHICLE COLLISION QUESTIONNAIRE
Please answer all questions completely:

1: Your name and address:

2: Phone Number: _____

3: Please describe the collision in your own words:

4: Where did the collision occur? City/Town: _____ State: _____

5: Date of collision: _____ Time: _____ AM PM

6: Were you the: driver passenger pedestrian

7: If passenger, were you in the front seat right rear seat left rear seat

8: What type of vehicle were you in? _____

9: What type was the other vehicle? _____

10: Did your vehicle strike the other vehicle? yes no

11: Was your car struck by the other vehicle? yes no

12: What direction was your vehicle going? _____

13: What direction was the other vehicle going? _____

14: Was the impact from: the front the rear the left side the right side

15: What was the approximate speed at the time of the impact?

16: Your vehicle _____ mph Other vehicle _____ mph

17: What was the weather at the time of the collision? dry wet icy

18: Was your vehicle in: park neutral in gear moving stopped

19: Were your brakes being applied? yes no

20: Was your vehicle shoved: forward backward sideways

21: Were you shoved: forward whipped backward

22: Did your seat have a head restraint (headrest?) yes no

Patient Name: _____

Date: _____

23: If yes, what was the position low mid-position high

24: Did your head ride over the headrest? yes no

25: Did your hat/glasses end up in the back seat or rear window? yes no

26: Did any other part of your body hit the interior of the vehicle? yes no

27: If yes, please specify: seatbelt restraints steering wheel dashboard
 windshield side door side window other _____

28: Which part of your body? chest head chin face R L knee

R L shoulder R L hand other _____

29: Were you holding on to the steering wheel? yes no

30: Did you brace your arms against the dash? yes no

31: Did you brace your legs against the floorboard? yes no

32: Was your ankle turned? yes no

33: Did the vehicle go into a spin or roll as a result of the impact? yes no

If yes, explain: _____

34: How much damage was there to the outside of the vehicle? none some a lot

35: How much damage was there to the inside of the vehicle? none some a lot

36: At the point of impact, where did you experience pain? Be specific:

37: Immediately after the accident were you: conscious dazed unconscious

38: If you lost consciousness, how long? _____

39: Were you wearing a seat belt? yes no

40: Did the belt have a shoulder harness? yes no

If yes, did it contribute to the pain you are experiencing? yes no

41: At the time of impact were you: looking straight ahead looking to the right

looking to the left looking down looking up

42: Did the seat break as a result of the impact? yes no

43: Were you braced for the impact? yes no

44: Were you surprised by the impact? yes no

45: Did you go to the hospital? yes no

46: If yes, when? right after the accident next day other _____

47: If yes, how did you get there? ambulance other: _____

Patient Name: _____

Date: _____

48: If by ambulance, did the ambulance attendants place you in a: neck brace

back brace other _____

49: Any medication or medical supplies given? _____

50: Did you have x-rays taken at the hospital? yes no

51: If you went to the hospital, please answer the following:

Name of hospital _____

Treatment Received _____

52: Have you had any similar problems before? yes no

If yes, explain: _____

53: Are you diabetic? yes no

54: Do you have high blood pressure? yes no

55: Do you have low blood pressure? yes no

56: Do you have arthritis or degenerative joint disease? yes no

57: What type of work do you do? _____

58: What are your job requirements? _____

59: Have you lost any days of work from this injury? yes no

If yes, give dates: _____

Patient Name: _____

Date: _____

_____ Doctor Reviewed with Patient

Doctor Signature: _____ Date: _____

PATIENT'S NAME: _____ HR#: _____ DATE: _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sit to Stand	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Climb Stairs	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Pet Care	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Extended Computer Use	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Lift Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Read/Concentrate	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Getting Dressed	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Shaving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sexual Activities	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sleep	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Sitting	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Standing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Yard work	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Walking	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Washing/Bathing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sweeping/Vacuuming	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Dishes	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Laundry	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Garbage	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Driving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Other: _____	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

PATIENT'S NAME: _____ HR#: _____ DATE: _____

REVIEW OF SYSTEMS

Please mark: **P** for in the Past **C** for Currently have **N** for Never

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pregnant (Now) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Jaw Pain, TMJ | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Tremors | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Pain w/Cough/Sneeze | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menopausal Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Foot or Knee Problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Problem | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression | <input type="checkbox"/> PMS | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers | | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes | | <input type="checkbox"/> Allergies | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Hepatitis (A,B,C) |

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

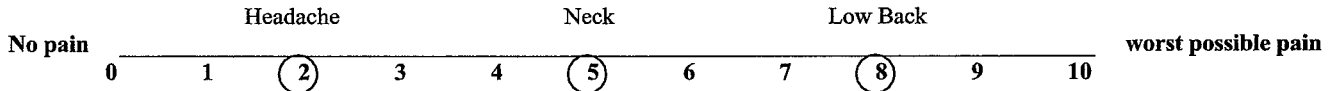
Date _____

Please read carefully:

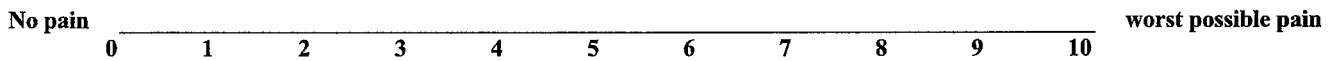
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

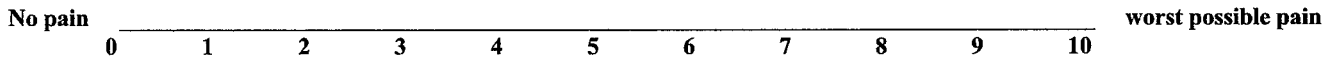
Example:



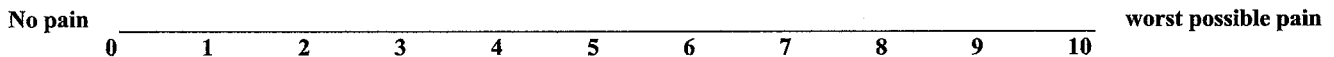
1 – What is your pain RIGHT NOW?



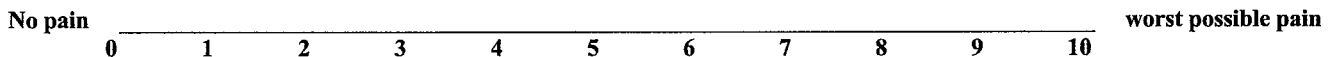
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

Examiner _____

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Informed Consent to Chiropractic Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractor care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness name: _____ Signature: _____ Date: _____

Anderson Spine and Injury Chiropractic Center
122 E West Pkwy Anderson, SC 29621

Clay Wickiser, D.C.
864-226-8868
wickpm122@gmail.com

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff. **Keep this page for your records.**

YOUR RIGHTS:

1. To inspect or obtain a copy of your records, usually within 30 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address).
4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
5. To receive an accounting of disclosures (those with whom we've shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

USES AND DISCLOSURES:

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures - an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient's death.
9. For workers' compensation claims, law enforcement purposes or with a law enforcement official, and other government requests - including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency - in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails - we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

COMPLAINT:

If you wish to make a complaint about how we handle your health information, please contact our privacy official using the information noted above. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

U.S. Dept. of Health and Human Services, Office of Civil Rights
200 Independence Avenue, SW, Washington DC 20201
877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued ...

Please complete the following where indicated and return to our front desk staff.

Patient initials: _____ - retaining page 1 of 2

I hereby acknowledge I have read and received a copy of Anderson Spine and Injury Chiropractic Center Privacy Practices Notice.

I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.

I am aware an extended detail version of this "Notice" is available to me upon request.

At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

_____ Parent or guardian of minor patient

_____ Guardian or conservator of an incompetent patient

_____ Beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only

Signed form received by: _____

Reason acknowledgment not obtained: _____

Efforts to obtain: _____

PATIENT'S NAME: _____ HR#: _____ DATE: _____

Anderson Spine and Injury Chiropractic Center

ASSIGNMENT OF PROCEEDS, LIENS, AND AUTHORIZATION

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") to pay directly and exclusively to the name of Anderson Spine and Injury Chiropractic Center ("ASICC" or "Office") such sums as may be owing to ASICC for charges incurred by me at the Office relating to my condition ("charges") with such payments to be made exclusively in the name of Anderson Spine and Injury Chiropractic Center. I further grant a lien to ASICC with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein, "Assignment and Lien"), "benefits" shall include, but no limit to, proceeds from any settlement, release agreement, judgment, verdict, or attorney retainer agreement, as well as any proceeds relating to commercial health or group insurance, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability coverage, disability benefits, workers' compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein, whether in compensation for medical expenses or any expenses or any other type of damage recognized by law.

In the event that I retain one or more attorneys to represent me in the matter who are not located in South Carolina, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers as defined above to release to ASICC any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this Office to file a copy of the Assignment and Lien, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize ASICC to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize ASICC to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless if these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due to ASICC for their services. This Assignment and Lien does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse ASICC for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual consent of ASICC and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of the authorizations conflict with the terms of the Assignment and Lien.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

Name of Custodial Parent or Legal Guardian: _____

Parent/Guardian's Signature: _____ Date: _____

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

There is a possibility that I a may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that that x-ray films not be taken because: _____

Date of last menstrual period: _____

Patient's Signature

Date