FAMILY BACK & NECK CARE CENTER

CHIROPRACTIC CENTER

19110 Montgomery Village Ave. • Suite 200 • Gaithersburg, MD 20879 • Phone: (301) 548-9079 • Fax: (301) 548-0923

CONFIDENTIAL PATIENT INTAKE FORM

Name_____ Date _____ Date Of Accident_____
Address_____State_____ Zip_____
H. Phone:_____ Cell Phone:_____ Date of Birth_____ Age_____
Referred by_____ Social Security #_____
Occupation_____Employer_____
Marital Status S M D W Spouse Name_____
Have you been seen by a Chiropractic before? Yes___ No___ If Yes Where?_____

ATTORNEY NAME:_____ **ATTORNEY'SPHONE:**_____
In case of emergency, contact: name_____ Relationship_____
Phone Number: ( ) _____

INSURANCE INFORMATION (FILL OUT ALL THAT APPLY)

Auto Accident/MTA/Pedestrian/Motorcycle
Does any member of your household own a car? Yes__ No __ In what state did your accident occur?_____
Do you have pip? Yes__ No __ If yes: PIP Amount __2,500 ____5,000 ___7,500 __Other amount_____
Policy Holder Information: Name of Insured:_____ Name of driver: _____
Make/Model of Vehicle:_____ It was: ___ Your own _____ Rented _____ Others _____
Insurance Company:_____ Policy #: _____ Claim #: _____

MEDICAL TREATMENT SINCE THE ACCIDENT:

Have you been treated by your private physician? Yes _____ No _____ Name/Phone _____
Date of Visit: _____
Were you treated at another medical clinic or ER? Yes _____ No _____ Name/Phone _____
Date of Visit: _____
When did you go for care? _____Right after accident _____Several hours later _____Next day
Other?_____
Where you given a disability certificate? Yes _____ No _____ If yes: From_____ To _____
Did you attempt to treat yourself? Yes _____ No _____ How? ___Heat/Cold ___Exercises ____ Bed rest
Other? _____
Is this condition interfering with Work?_____ Sleep?_____Routine?_____Other?_____
Is this condition progressively getting: worse?_____

A. Car Accident:

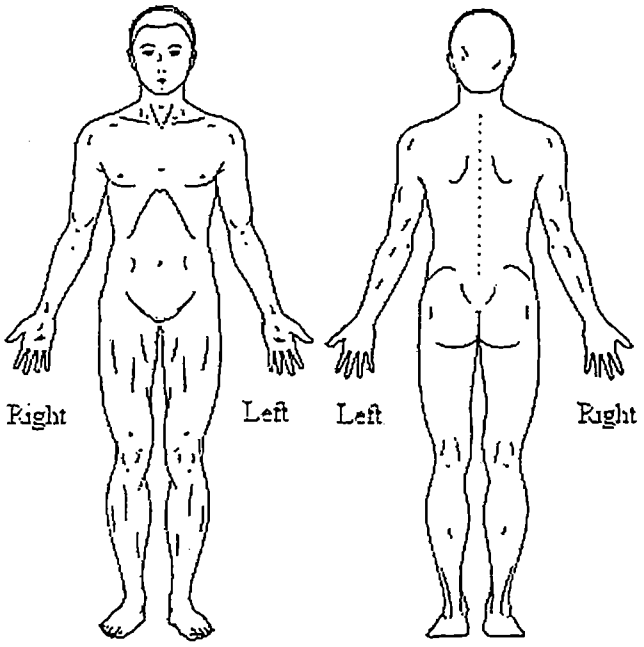
Were you the: _____ Driver ____ Passenger, If so: ____ Rear-seated _____ Front-seated
Accident happened when your car was: ___ Moving ____Stopped _____Parked
You were in a: _____ Car ____ Van _____Truck ____ Taxi Cab _____SUV
It was Company Car? ____ No ____ Yes
What type of vehicle hit you? ____ Car ___Truck ___ Van _____ Bus _____SUV _____Taxi
Was impact from: ____ Front ____ Rear ____ Left ____Right ____Other _____
Did your car impact another vehicle? ____Yes ___ No
Did your car Impact another Structure? ____ Yes ____ No If Yes, Explain: _____
Upon collision your body: ___ Move backward and Forward ____ Twisted around ___Was thrown from side to side
Were you Seat-belted? ____Yes ____ No If Yes, did you sustain injuries from seat-belt? ____NO ___YES
Did your airbag deploy? ____YES ___NO

B: POST-ACCIDENT INFORMATION (FOR ALL ACCIDENTS)

At the scene, there were: ____ Police ____ Fire Department ____ Ambulance

Complaints:
1- Are you able to perform work duties? ____No ____ Yes ___Yes, but with limitation ___Do not work
2- Are there limitation in performing(check all the apply): ___Domestic duties ____Sports ____ Hobbies
3 Activities or Movement that are painful too perform: ____ Sitting ____Standing ____Walking ____Bending ____Lying Down.

Using the symbols below, mark on the pictures where you feel pain.



Numbness ____

Dull Ache ____

Burning ____

Sharp/Stabbing ____

Pins, Needles ____

Other _____

Please mark any of the following conditions or symptoms that you have now or have experienced:
Other Symptoms:

O Headaches
O Neck Pain
O Sleeping Problems
O Low Back Pain
O Nervousness
O Tension
O Irritability
O Dizziness
O Pain Between Shoulders
O Neck Stiff
O Joint Swelling
O Fever
O Loss of Balance
O Ringing in Ears
O Jaw/TMJ Problems

O Pain in Hands or Arms
O Numbness in Hands or Arms
O Pain in Legs or Feet
O Numbness in Legs or Feet
O Fatigue
O Depression
O Lights Bother Eyes
O Loss of Memory
O Shoulder Pain
O Sinus
O Shortness of Breath
O Asthma
O Allergies
O Cold Hands
O Cold Feet

O Chest Pains
O Heart Attack
O High Blood Pressure
O Stroke
O Cancer
O Painful Urination
O Diabetes
O Diarrhea
O Constipation
O Stomach Upset
O Heartburn/Reflux
O Weight Loss
O Loss of Smell or Taste
O Menstrual Cramps
O Menopause

Are you under medical care for any condition?_____

What Medications are you taking?_____

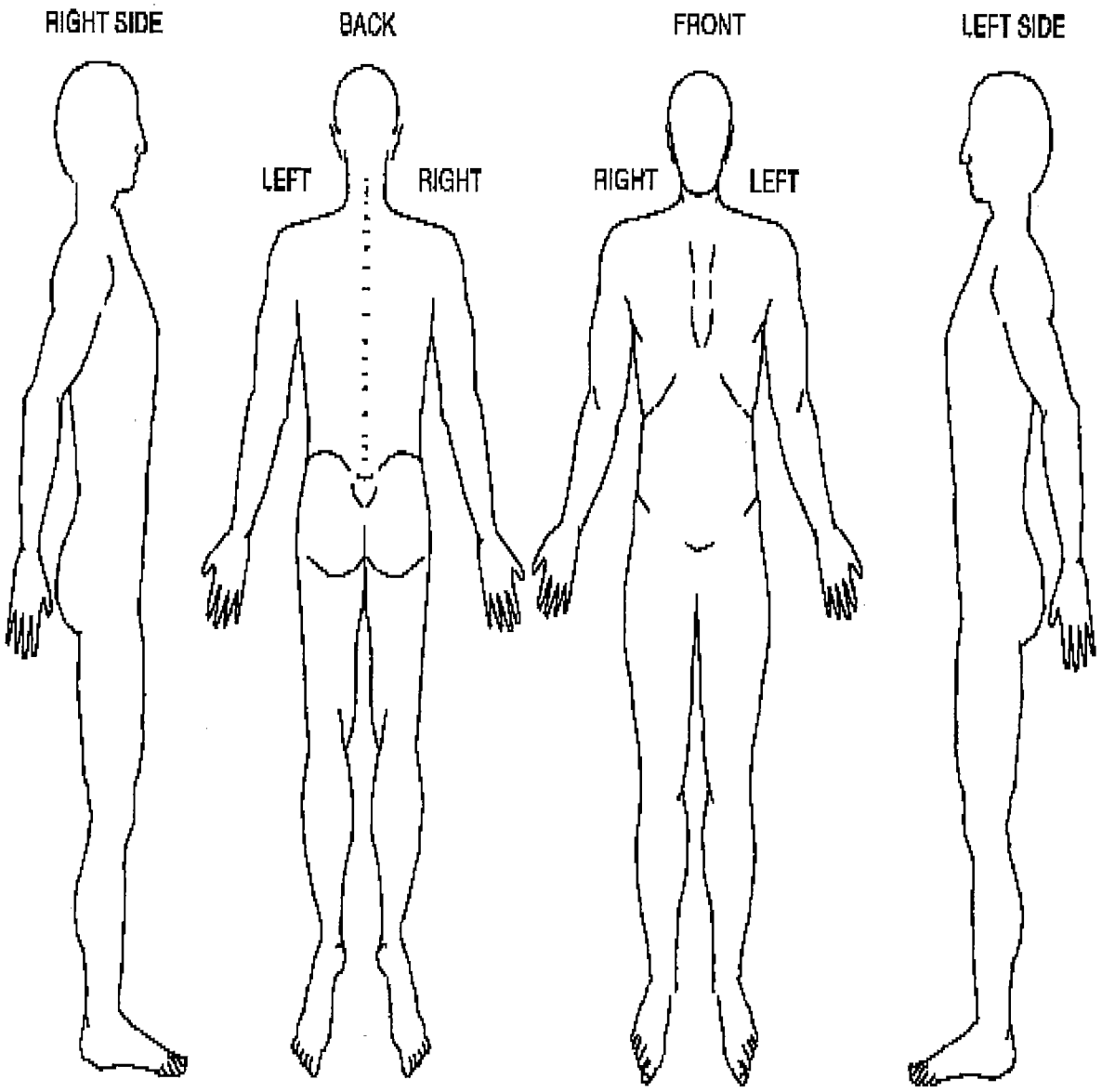
How long?_____ Have you had surgery?_____ What?_____ When?_____

What side effects have you experienced from the drugs and surgery?_____

Patient Signature_____ Date_____

ACCT#: _____ NAME: _____ DATE: _____

Mark (X) on the picture where you feel pain.
Marque (X) donde sient dolor.



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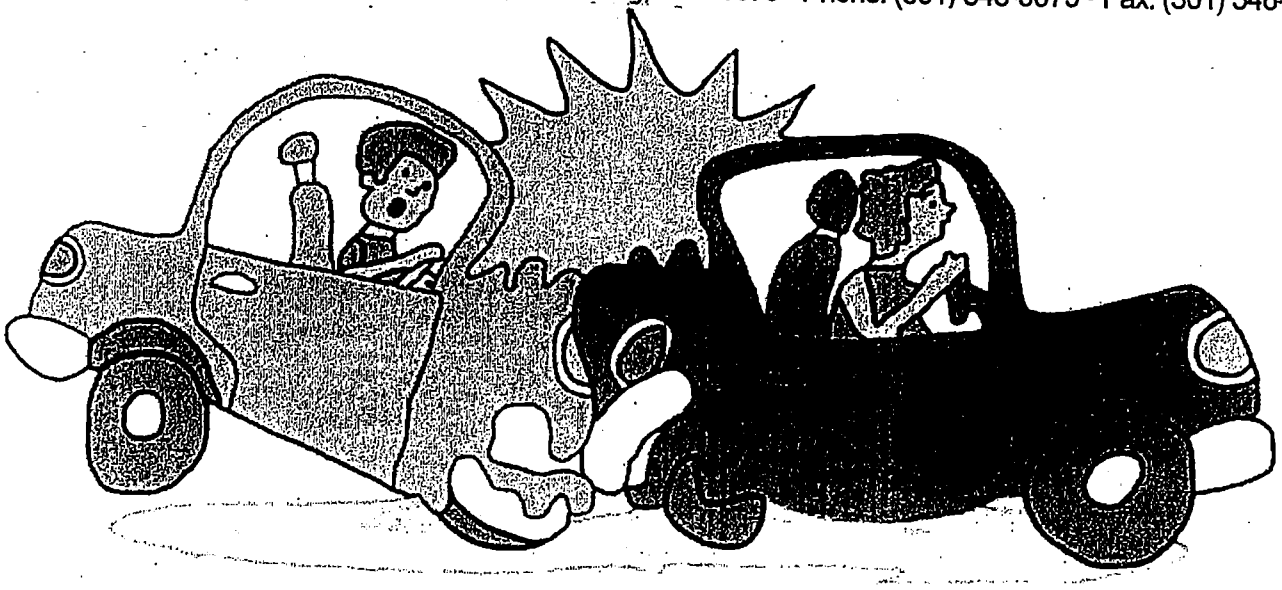

How much damage was done to the vehicle you were in?

Please check one:

- ☐ Less than $1,000.
- ☐ $1,000 to $2,000.
- ☐ $2,000 to $3,000.
- ☐ More than $3,000.
- ☐ Total.

Patient's Name: _____

Patient's Signature: _____ Date: _____

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ASSIGNMENT AND AUTHORIZATION

TO: _____
_____
_____

FROM: Family Back & Neck Care Center
19110 Montgomery Village Ave,# 200
Gaithersburg, MD 20879
301-548-9079 Fax 301-548-0923

Patient's Name: _____

Date Of Accident: _____

I do hereby authorized the above doctors to furnish you, my attorney with a full report of this examination, diagnosis, treatment, prognosis, etc., of my self in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reasons of any other bills that are due his office and to withhold such sums from any settlement, Judgment or verdict as may be necessary to adequately protect said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney or myself as the results of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement so is made solely of said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment in not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Patient's Signature _____ Date: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor above named.

Attorney's Signature: _____ Date: _____

Attorneys: Please date, sign and return one copy to doctor's office at once along with a **LETTER OF REPRESENTATION**.

I hereby authorize _____ to make payment directly to:
Insurance Company

Family Back & Neck Care Center
19110 Montgomery Village Ave
Ste#200
Gaithersburg, MD 20879

The expense benefit allowable, and otherwise payable to me under my current insurance policy, toward the total charges for professional services rendered by this clinic.

I authorize this clinic to release any information, pertinent to my case/injury to any insurance company, adjustor, and attorney involved in this case. I hereby release this clinic of nay consequence thereof.

I understand that I am financially responsible for all charges incurred at this clinic including any and all deductible, co-payment and co-insurance. Should it be necessary to take legal action to collect any amount owing under this agreement. I will be responsible for all attorney, collection fees, and any other cost incurred in collecting the amount owed.

X_____ _____
Patient Signature/Guardian Date

X_____
Print Name

Note: Parent or guardian must sign for minor child.

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PATIENT PREGNANCY DISCLAIMER

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having x-rays taken at this time and grant permission for this procedure. In so doing I release the doctor/clinic from responsibility for potential damage arising from this procedure.

At the present time,

_____ I am sure that I am not pregnant.

_____ It is possible that I could be pregnant.

_____ I am pregnant.

_____ _____

Signature-Patient Date

_____ _____

Signature-Witness Date

ASSIGNMENT OF PIP AND MED-EXPENSE BENEFITS

To Whom it may Concern:

I hereby authorize and direct any insurance company with whom I may make a claim for PIP and/or Med-pay/Med-Expense benefits, and/or my attorney to paid directly to **"Family Back & Neck Care Center"**, any money that is owed to this health provider for services rendered to me.

Do NOT send the PIP, Med-Pay, or Med-Expense benefit for these services to anyone other than this provider Do not send this money to my attorney or me.

In the event that any insurance company that is obligated to reimburse me for charges I incur with this health provider refuse to make such payments after demand is made by either me or this health privider, I hereby assign and transfer to this health provider any and all caused of action that I have against said insurance company, including but not limited to the right to bring a lawsuit, for the failure to pay the available PIP and/ or Med-Expense benefits up to the amount of this health provider's full bill.

I authorize this health provider to bring any such cause of action either in my name or in this health provider's name. I further authorize this health provider to compromise, settle or otherwise resolve any such claim arising out of the insurance company's failure to pay to this health provider the full limit of available PIP or Med-Expense benefit up to the amount of its full bill.

I understand that I remain personall responsible for the total amounts due to this health provider for its services. I understand that payment is due at the time services. I understand that payment is due at the time services are rendered, and that this health provider is providing a courtesy to me by trying to have the bill paid through alternative sources. I agree that this document does not constitute any consideration for this health provider to await payment, and that payment may be demanded from me immediately upon the rendering of services.

I authorize this health provider to release any information pertinent to my case to any insurance company or attorney to facilitate the collection of my bill. I agree that this health provider be given Power of Attorney to endorse or sign my name on any and all check for payment of my doctor bill.

Patient: _____ Date: _____

Witness: _____

DISCLOSURE & CONSENT
CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

print name

signature of patient

date signed

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or physically or legally incapacitated:

print name of patient

print name of patient's representative

signature of patient's representative

as: relationship or authority of patient's representative

date signed

To be completed by doctor or staff

witness to patient's signature

translated by

To be completed by doctor or staff

date

date

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

The Family Back and Neck Care Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with The Family Back and Neck Care Center."

"It is our policy to provide a substitute health care provider, authorized by The Family Back and Neck Care Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to The Family Back and Neck Care Center for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Organ Donation.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of The Family Back and Neck Care Center sponsored fund-raising events."

Change of Ownership.
In the event that The Family Back and Neck Care Center is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

Ø You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that The Family Back and Neck Care Center is not required to agree to the restriction that you requested.
Ø You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
Ø You have the right to inspect and copy your health information.
Ø You have a right to request that The Family Back and Neck Care Center amend your protected health information. Please be advised, however, that The Family Back and Neck Care Center is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.
Ø You have a right to receive an accounting of disclosures of your protected health information made by The Family Back and Neck Care Center
Ø You have a right to a paper copy of this Notice of Privacy Practices at any time upon request

Changes to this Notice of Privacy Practices
The Family Back and Neck Care Center reserves the right to amend this Notice ofPrivacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, The Family Back and Neck Care Center is required by law to comply with this Notice.

The Family Back and Neck Care Center is required by law to maintain the privacy of your health information and to provide you with notice ofits legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: The Family Back and Neck Care Center by callingthis office at 301-548-9079. If Dr. Stephen Taylor is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints
Complaints about your Privacy rights, or how The Family Back and NeckCare Center has handled your health information should be directed to Dr. Stephen Taylor by calling this office at 301-548-9079. If Dr. Stephen Taylor is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formd complaint to:

DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201
This notice is effective as of 04 / 14 / 03

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide The Family Back and Neck Care Center with my authorization and consent to use and disclosedmy protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

Patient's Name (print) _____ Patient's Signature _____ Date _____

Authorized Facility Signature _____ Date _____