Welcome

Name/Nombre: _____
Last name/Apellido First/Primero

Address/Direccion: _____ Apt.#: _____

City/Ciudad: _____ State/Estado: _____ Zip: _____

Home#: _____ Cell#: _____

DOB/Fecha de nacimiento: ____/____/____ ( )Single ( )Married ( )Divorced ( )Widowed

SS#: _____ ( ) Female ( )Male

Whom may we notify in an emergency? _____ **Relationship** _____
Tel.#: _____ YOUR E-MAIL ADDRESS: _____

EMPLOYER

Name: _____ Occupation: _____

Address: _____ Work#: _____

INJURY

Please describe where you are having pain/porfavor describa donde siente dolor.

_____

_____

Have you lost any days of work? ( )Yes ( )No if so, when: _____

List any other Doctors seen for this: _____

Please list medication(s) presently taking: _____

HEALTH HISTORY

List Previous surgeries/disease with dates: _____

Allergies to any medication? ( )Yes ( )No _____

Past Illnesses? _____

Have you ever been treated by a Chiropractor before ( )Yes ( )No If yes, who? _____

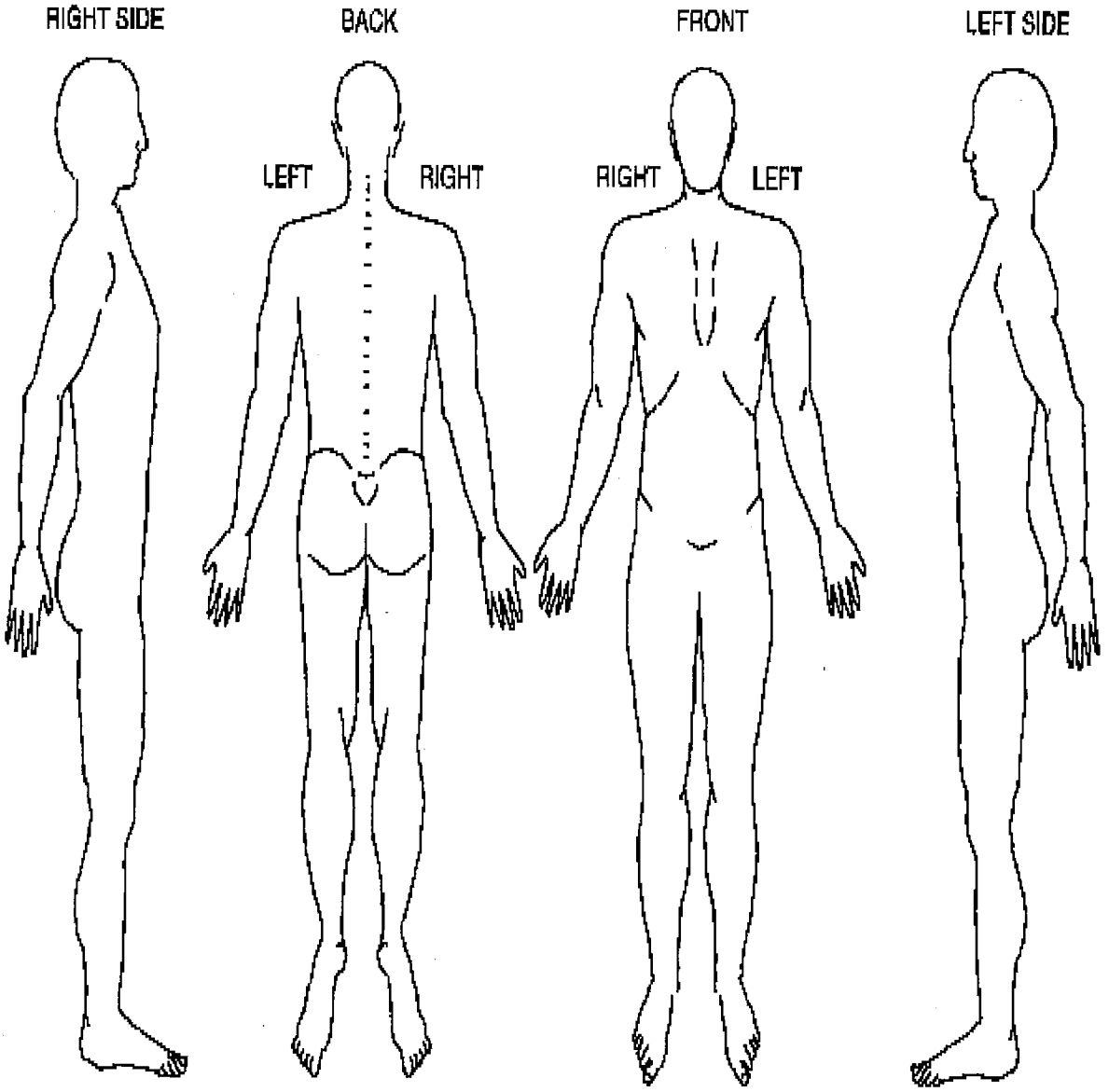
Have you been treated for any health condition by a physician in the last year? _____

Are you pregnant? ( )Yes ( )No/ how far along? _____

Please continue on back

ACCT#: _____ NAME: _____ DATE: _____

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



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.

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

FAMILY BACK & NECK CARE CENTER

CHIROPRACTIC CENTER

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

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 infomation 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 of Privacy 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 of its 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 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.

Complaints
Complaints about your Privacy rights, or how The Family Back and Neck Care 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 formal 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 disclose my 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 _____