WELCOME

one ABOUT YOU

Today's Date: ____/____/____ File #: ____

Patient Name: ____
LAST FIRST MI

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: ____ SS#: ____

Mailing Address: ____

____
CITY STATE ZIP

Home Phone #: (____) ____

Work Phone #: (____) ____ Ext: ____

Cell Phone #: (____) ____

E-mail Address: ____

Referred By: ____

Employer: ____ How Long? ____

Employer's Address: ____

____
CITY STATE ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

two INSURANCE INFO

Primary Insurance

Co. Name: ____

Address: ____

____
CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

Secondary Insurance

Co. Name: ____

Address: ____

____
CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

three ACCOUNT INFO

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____

____
CITY STATE ZIP

SS #: ____

Drivers License #: ____

Work Phone #: (____) ____

Payment method: ❑ Cash ❑ Check

____ ____/____
❑ Credit Card - Enter card # above (if accepted)

____ I hereby authorize assignment of my insurance
Initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

four IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

PLEASE CONTINUE ON BACK

five REASON FOR VISIT

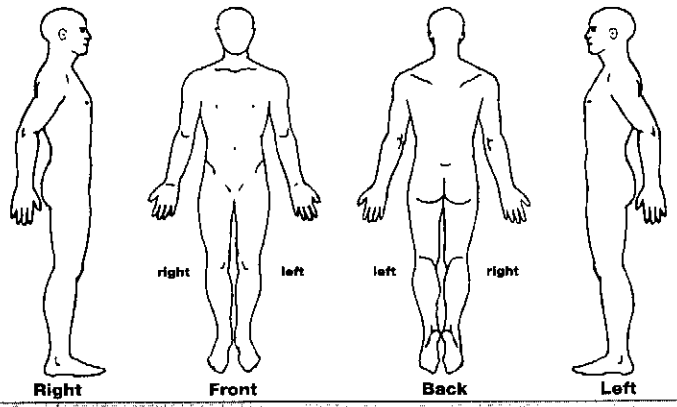
Reason for today's visit: ❑ Emergency ❑ New injury ❑ Old injury ❑ Chronic pain ❑ Wellness
Are you in pain: ❑ Yes ❑ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense
Did your injury occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity
When did your condition/accident occur? ___/___/___ Where did your injury occur? _____
Please explain what happened: _____
Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes.
Is your condition interfering with your: ❑ Work ❑ Sleep or ❑ Daily routine? If so, how: _____

Has this or something similar happened in the past?
❑ Yes ❑ No Explain: _____

Using the adjacent body charts, please circle all affected areas.

Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where? _____

Have you ever been treated by a Chiropractor? ❑Yes ❑No
Clinic or Dr's name: _____
Clinic phone#: _____



six HEALTH HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers(including aspirin) ❑ Muscle relaxers
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N HIV+ / AIDS / ARC
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Anemia / Diabetes
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe / Frequent Headaches	Y N Kidney Problems
Y N Ulcers / Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema / Asthma	Y N Tuberculosis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/Implants	Y N Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____
List any past serious accidents with dates: _____
Please list anything that you may be allergic to: _____
Family Health History: _____
Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you exercise? ❑ No ❑ Yes ____ hours per week
Do you smoke? ❑ No ❑ Yes How much? _____ How long? _____
Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports Are you dieting: ❑No ❑Yes Since: ___/___/___
For woman: Are you taking Birth Control? ❑ Yes ❑ No
Are you Nursing? ❑ Yes ❑ No Are you Pregnant? ❑ No ❑ Yes If so, how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)
Initials ___/___/___ Date
Comments
Initials ___/___/___ Date
Comments
Initials ___/___/___ Date
Comments

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

REED CHIROPRACTIC ASSOCIATES, P.C.
22270 HIGHWAY 72 E
ATHENS, AL 35613

X-RAY CONSENT FORM

Patient Name: _____ File #: _____ Date: _____

During your examination, the doctor may feel that x-rays will be needed in order to diagnosis your condition. We would like to make you aware that x-rays may be required, in order, to administer treatment. In order to perform x-rays on any patient our office requires the patients consent for such tests to be performed.

PLEASE CHOOSE ONE:

_____ I understand that my doctor may need x-rays in order to diagnosis my condition and **I give permission of all needed diagnostic tests.**

_____ I understand that my condition may require my doctor to take x-rays to further diagnosis my symptoms. **I choose NOT to have any x-rays at this time and release my doctor of all liabilities.**

Signature: _____ **Date:** _____

FEMALES ONLY:

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

I am pregnant	_____ yes	_____ no	_____ don't know
I could be pregnant	_____ yes	_____ no	_____ don't know
My **menstrual period is late**	_____ yes	_____ no	_____ don't know
I have: **IUD**	_____ yes	_____ no	
irregular menstrual periods	_____ yes	_____ no	
My last menstrual period began	_____		
had a hysterectomy	_____ yes	_____ no	
begun menopause	_____ yes	_____ no	

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by my doctor.

Signature: _____ **Date:** _____

EMAIL AND MESSAGE AUTHORIZATION

E-Mail:

I, _____, do hereby give consent to Reed Chiropractic Associates, employees, and Jason Reed, DC to use my e-mail address for possible future communication. I understand I can be removed from the e-mail list at any time by informing the staff at Reed Chiropractic Associates.

Messaging:

I, _____, do hereby give consent to Reed Chiropractic Associates, employees, and Jason Reed, DC to leave detailed messages for me on my answering machine or with the following individuals and also give permission for my accounting records, insurance information, and/or medical records to be discussed with the following individuals:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Financial Agreement

Insurance is considered a method to cover the cost of services provided in this office at your coverage rate outlined by each individual insurance company. This office is happy to file all claims with your insurance company but we can not be held responsible for what is covered or not covered. Please note there are some insurance companies that this office is not considered an in network provider for. The office staff does its best to communicate any information about your insurance benefits that we are given but the final determination will always fall with the insurance company. It is your responsibility to be informed of your individual insurance coverage before coming in for any appointments. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **EVERY INSURANCE PLAN IS DIFFERENT**. It is your ultimate responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance. _____ **initial**

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, RCA, P.C. shall be entitled to reasonable be entitled to reasonable attorney's fees and for cost of collection.

_____ _____

Patient Signature Insureds signature

_____

Date

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or insurance employee health care benefits coverage with the above captioned, and hereby assign and convey directly to RCA, P.C. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insures and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

_____ _____

Signature of Insured/Guardian Date

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including but not limited to various modes of manual therapy, physiological therapeutics, traction, modalities, exercise, physical therapy, diagnostic X-rays, nerve conduction studies, and bone density test on me (or on the patient named below, for whom I am legally responsible) by the doctor(s) of chiropractic, as an employee, of Reed Chiropractic Associates, P.C. and/or other licensed doctors of chiropractic who now or in the future work at the clinic.

I have had an opportunity to discuss with the doctor of chiropractic an/or with other office or clinic personnel and/or other medical professionals the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed and vary person to person.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment , including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise prudent judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for an y future condition(s) for which I seek treatment. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing at any time for all *future* procedures, with the understanding that any such revocation shall not apply to the extent that Reed Chiropractic Associates, P.C. Has already taken action in reliance on this consent.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Patient Name: _____

Date of Birth: _____

Patient or Guardian Signature:_____Date:_____

Witness Signature:_____Date:_____

Please Read and Initial After Each Paragraph

All patients will be seen in order of appointment time, not arrival time. While walk ins are welcomed, they will be worked in among already scheduled patients and should expect some wait time. All of us at Reed Chiropractic work hard to see that all patients are brought back and receive treatment in the most timely and efficient manner possible.

Initial here please ____

It is the policy of Reed Chiropractic to monitor and manage all appointment no shows. Any patient that fails to arrive without giving 24 hours notice is considered a no show. The first time a patient is a no show they will receive a warning. The second no show will result in a $25 missed appointment charge. This charge is the patient's responsibility and will not be covered by any insurance company. The $25 must be paid before the patient can be seen again. Any patient that consistently misses 5 times may be dismissed from care.

Initial here please ____

Reed Chiropractic participates in most insurance plans. If you are unsure of your insurance coverage, please call the insurance company for clarification before your appointment. Remember your health coverage is a contract between you and your insurance company. This office will assist you in getting full benefits from your carrier. Any co pays, co insurance or deductibles will be due at the time of service. If you have trouble paying your bill, there are payment options available. Please discuss any issues with the billing manager BEFORE your bill becomes past due. If you accrue a balance with no effort to pay, you may be denied care in this office.

Initial here please ____

Insurance is considered a method to cover the cost of services provided in this office at your coverage rate outlined by each individual insurance company. This office is happy to file all claims with your insurance company but we can not be held responsible for what is covered or not covered. Please note there are some insurance companies that this office is not considered an in network provider for. The office staff does its best to communicate any information about your insurance benefits that we are given but the final determination will always fall with the insurance company. It is your responsibility to be informed of your individual insurance coverage before coming in for any appointments. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. EVERY INSURANCE PLAN IS DIFFERENT. It is your ultimate responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance.

Initial here please ____

Reed Chiropractic is happy to provide its patients with copies of any medical records or x rays they might need. Please know there is a small charge for these copies. There is a $7 charge for x rays copied to a disk and a per page fee for any medical records requested. This fee is not covered by any insurance. Also, there is a 48 hour waiting period after the request is received before any copies will be available for pickup.

Initial here please ____

REED CHIROPRACTIC ASSOCIATES, P.C.
Jason T. Reed, DC CCEP
22270 Highway 72 E.
Athens, AL 35613
(256) 206-9722; Fax (256) 206-9725

HIPPA Declaration

The Practice:

(a) Is required by federal law to maintain the privacy of you PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to you PHI
(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law
(c) Is required to abide by the terms of the Privacy Notice
(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains
(e) Will distribute any revised Privacy Notice to you prior to implementation
(f) Will not retaliate against you for filing a complain

EFFECTIVE DATE

This Notice is in effect as of April 6th, 2009.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

_____ _____
Patient Date

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Acknowledgment
Patient's acknowledgment of this notice could not be obtained because:

__ Patient refused to sign
__ Communication barrier prohibited obtaining acknowledgment
__ Emergency circumstances
__ Other
Details:

_____ _____
Signature of Practice Date