ALLCARE
"Experience the Difference"

Laurel Historic Main Street
525 Main Street, Suite 105
Laurel, MD 20707
301-725-6884 Office
301-850-3333 Fax

Bowie Town Center
4345 Northview Drive
Bowie, MD 20716
301-464-5656 Office
301-850-3333 Fax

Silver Spring/White Oak
11231 Lockwood Drive
Silver Spring, MD 20901
301-289-7789 Office
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AUTO CRASH QUESTIONNAIRE

Date:_____

Name: First _____ **Last** _____**MI** _____
Attorney Name: _____ **Attorney Ph #:** _____
Date of injury: _____ **Date of Birth:** _____ **Age** _____ **Gender: M F**
SS#: _____-_____-_____ **Height:** _____ **Weight:**_____
Address: Street: _____ **Apt:**_____
City:_____**State:** _____ **Zip:** _____
Your e-mail address:_____
Cell Ph #: _____ **Home Ph #:** _____

Family Status: M S D Separated Widowed Single Parent
Number of Children: 1 2 3 4 5 Other_____
Habits: Smoker Pk/day Years Non-smoker
Alcohol: Never Social Light Moderate Heavy
Employer:_____ **Work Ph #**_____
Address:_____
Currently: Unemployed Self-Employed Retired Disabled Student

In case of emergency: Name:_____
Relationship to you_____**Phone #:**_____
Address:_____

INSURANCE INFORMATION *(fill out all that apply)*
In what state did your accident occur? _____
Do you have **PIP**? YES NO If **Yes:** PIP **Amount** 2,500 5,000 7,500
Other _____
Do you have **Med Pay**? YES NO If **Yes:** Med Pay **Amount** 2,500 5,000 7,000
Other_____
Name of Insured: _____
Name of Driver:_____
Your Insurance Co:_____
Your Policy #: _____
Your Claim #:_____
Your Adjuster's Name:_____
Adjuster's Phone #:_____ _____

Information about ***THE OTHER*** vehicle that struck you:
Driver's Name:_____ Insured's Name: _____
Auto Insurance _____
Policy # _____Claim #:_____

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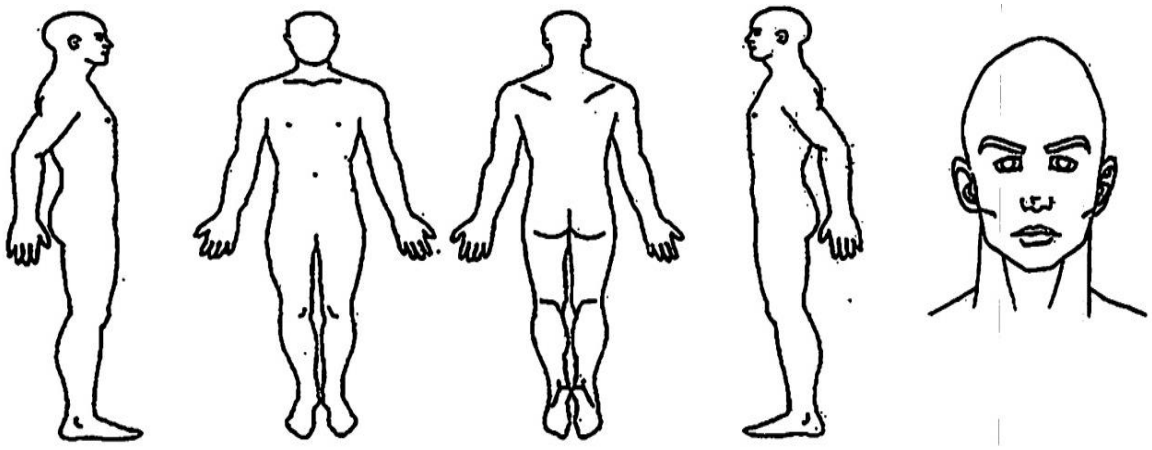
Name: First _____ **Last** _____**DOI**_____

GENERAL INFORMATION: Please Circle Your Answer.

Are you Right or Left-handed? Right Left
Occupation:_____ For how long? _____Years _____Months
Allergies:_____
Hobbies:_____
Exercise:_____
Family Medical History:_____

Did you sustain any visible (bruises, laceration, etc.) and as a result of the crash? YES NO
If *YES*, Please indicate and label the areas:
Bruises – **B** Lacerations – **L** Stitches – **S** Abrasions -- **A** Scars -- **SC** Other – O



MEDICAL TREATMENT *SINCE* THE CRASH:

Have you been treated by your **private physician**? No Yes
Physician's Name/PH#:_____ Date:_____
Were you treated at a **Hospital** or Urgent Care Facility? No Yes
(*Name/Phone*) _____Date:_____
When did you go for care? Right after the accident Several hours later Next day
____Days later.
Were you transported by **Ambulance** from the scene? No Yes
Were you given a **disability** certificate? No Yes If Yes: From: _____To:_____
Did you take **TIME OFF** from work? No Yes If Yes: From: _____To:_____
Did you attempt to self-treat? No Yes Heat/Cold Exercises Bed Rest Other
(*Specify*):_____
Medications you're taking:_____
Have you had any crash or injuries **since** this crash? No, If Yes, Please explain_____
Are you having **relationship difficulties** since the crash? No Yes

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Name: First _____ **Last** _____**DOI** _____

CRASH QUESTIONNAIRE:

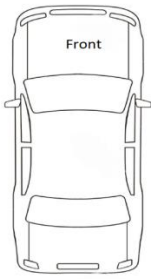
Type of Injury: **Auto** MTA-Bus Motorcycle Bicycle Pedestrian Work-Related Slip and Fall

Were you the: **Driver** **Passenger** Rear-seated Other:_____

Make and model of **your vehicle** _____ Year _____

Was the vehicle: Your own Rented Parent's Other: _____

DESCRIBE YOUR CRASH:

Your Vehicle was Struck: ___In the rear ___In the right rear ___In the left rear ___In the driver's side ___In the passenger's side ___In the front ___In the left front ___In the right front Other (Explain Below)_____ _____ _____ _____ _____ Was your vehicle **towed** from the scene? Yes No		**Your vehicle was:** ___Stopped at a traffic signal ___Stopped at a stop sign ___Stopped for a pedestrian ___Stopped in traffic ___At a complete stop ___Slowing down for a traffic signal ___Slowing down for a stop sign ___Slowing down for a pedestrian ___Slowing down for traffic ___Slowing down to turn ___Slowing down to park ___Making a right-hand turn ___Making a left-hand turn ___Making a U-Turn ___Moving with the flow of traffic ___Other_____
Your vehicle was struck by: ___A Car ___A Van ___A Pick-up Truck ___A Bus Other:_____ _____	**At the scene, there were:** ___Police ___Fire Dept ___Ambulance **Police Report Obtained:** ___Yes ___No	**Upon impact your vehicle was forced into:** ___Another vehicle ___A pole ___A wall ___A Curb Other:_____

Briefly **describe** how the crash happened:_____

_____

Damage to Your Vehicle was:

A) None or almost none B) Minimal (Below $1,000) C) Significant (Above $1000) D) Extensive ($3,000 or More)

Damage to the Other Vehicle was: None or almost none B) Minimal (Below $1,000) C) Significant (Above $1,000) D) Extensive ($3,000 or more)

Did you take photos of the crash? Yes No

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Name: First _____ **Last** _____**DOI**_____

Please Circle Your Answers:

Were you WEARING your seatbelt? YES NO
Did your AIRBAG deploy and hit you? YES NO
Did the SEATBACK reclined or you had to adjust it after the crash? YES NO
Did you have to adjust the HEADREST after the crash? YES NO
Were you: A) Sitting squarely in your seat B) Twisted in your seat C) Leaning forward
D) Leaning to the side
What was your HEAD position: A) Faced-forward B) Turned to the left C) Turned to the right
D) Unsure
Were you AWARE of the impending collision? YES NO
Did you BRACE for impact? YES NO
Was your head and body thrown BACKWARD and FORWARD in a forceful manner? YES NO
Was your head and body thrown from ONE SIDE to SIDE in a forceful manner? YES NO
Did the shoulder restraint of your seatbelt prevent you from hitting the steering wheel? YES NO
Did you hit your HEAD on the:
A) Steering wheel B) Windshield C) Visor D) Roof E) Side window F) Headrest
Other_____
Did the accident occur DURING: DAYTIME NIGHTIME Around what time:_____
Was the ROAD condition: DRY WET ICY SNOW/LEAF COVERED
At the moment of impact, your HANDS were: BOTH on steering wheel ONLY ONE on wheel Unsure

Please answer the following questions:

Since the crash, is there anything you have been **unable** to do?_____
_____
Since the crash, is there anything you have had **difficulty** doing?_____
_____
Since the crash, have you been able to continue with most of your **daily activities**? No Yes
_____

Do you have to pay for household assistance since the crash? No Yes

Describe your Current Complaint: Please Circle Your Answers

Headache Neck Pain Upper Back Pain Mid back Pain Low back Pain Shoulder Pain Numbness/Tingling Arm/Leg Pain Sciatica Pinched Nerves

Other/Describe:_____

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Please indicate ***WHERE* you are experiencing pain or symptoms related to your complaint.**

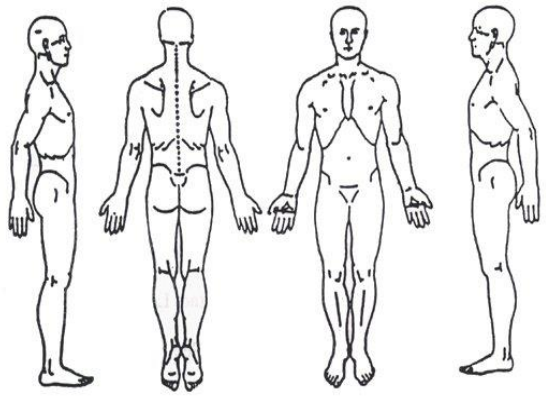
Use the letters to represent ***WHAT* type of pain.**

A = Aching **B = Burning Sensation**

C = Cramping **D = Dull Throbbing**

M =Sore ness **N = Numbness**

S = Sharp **T = Tingling**



Pain Scale: **1----------2----------3----------4----------5**

(Please rate your pain level from 1-5, 5 being worse possible pain)

How often are your symptoms present? 0-25% 26-50% 51-75% 76-100%

Does it interfere with? Work Sleep Daily Routine Recreation Other

_____

What makes it WORSE? Long Sitting Walking Bending Lifting Standing

Lying down Standing from seated position Other_____

Have you ever had this complaint in the past? No Yes – **If so, when?**

_____

What makes it BETTER? Rest Stretching Ice Heat Medications Massage

Since it started, is your symptom getting? Worse Better Same

Please check all of the following that apply to you:

High Blood Pressure Varicose vein Asthma Mark Morning Pain/Stiffness
Kidney Problems Gout Liver/Gallbladder Recent Fever
Abnormal Weight Loss Tumors Eye/Vision Problems Corticosteroid use
Ear/Hearing Problems Stomach Ulcer Heart Disease Taking Birth Control Pills
Loss of Bladder Control Loss of Bowel Control Carpel Tunnel Syndrome
Hepatitis Digestion Problems Pain Unrelieved Rest/Position Heart Attack
Thyroid Problems Prostate Problems Diabetes Stroke/CVA
Tuberculosis High Cholesterol Loss of Memory Osteoporosis
Pacemaker Gynecological Problems COPD Epilepsy/Seizures
Arthritis Depression Cancer_____ Hernia/Rupture

Surgeries: **Yes** **No**_____

Patient's Signature_____**Today's Date** _____

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Name: First _____ **Last** _____ **Date:**_____

NECK DISABILITY INDEX

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1---Pain Intensity

A I have no pain at the moment.
B The pain is mild at the moment.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain is severe, but comes and goes.
F The pain is worst imaginable at the moment.

SECTION 2---Personal Care (Washing, Dressing, Etc.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself but I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self-care.
F I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3---Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, ie, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4---Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5---Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours sleepless).

SECTION 6---Headaches

A I have no headaches at all
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 7---Concentration

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 8---Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 9---Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive at all.

SECTION 10---Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some neck pain.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D I am able to engage in a few of my recreational activities because of my neck pain.
E I can hardly do any recreational activities because of my neck pain.
F I cannot do any recreational activities at all.

Score: **Past:** **Current:**

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Name: First _____ **Last** _____**Date:**_____

REVISED OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRLCE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1---Pain Intensity

A The pain comes and goes and is very mild
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2---Personal Care

A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of pain, I am unable to do any washing or dressing without help.

SECTION 3---Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg, on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

SECTION 4---Walking

A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than ½ mile.
D Pain prevents me from walking more than ¼ mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

SECTION 5---Traveling

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 6---Sitting

A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than ½ hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

SECTION 7---Standing

A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than ½ hour without increasing pain.
E I cannot stand for longer than ten minutes without increasing pain.
F I avoid standing, because it increases the pain straight away.

SECTION 8---Sleeping

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than one-quarter.
D Because of pain, my normal night's sleep is reduced by less than one-half.
E Because of pain, my normal night's sleep is reduced by less than tree-quarters.
F Pain prevents me from sleeping at all.

SECTION 9---Social Life

A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, eg. dancing etc.
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my house.
F I have hardly any social life because of pain.

SECTION 10---Changing Degree of Pain

A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getter better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

Score: **Past:** **Current:**

MEDICAL REPORTS AND DOCTOR'S LIEN

The following agreement:

1. Should be read and signed if you do not wish to pay for each visit at the time of the visit.
2. Will allow us to deal directly with your employer, any insurance company and/or attorney that may be involved now or in the future.
3. Will allow your employer, attorney and/or insurance company, if we are awaiting payment, to pay us directly.
4. States that you understand all bills are your responsibility.

I do hereby authorize AllCare Chiropractic, LLC to furnish you, my employer, attorney and/or insurance company adjuster, with a full report of my examination, diagnosis, treatment, prognosis, charges incurred, etc.

I do hereby authorize and direct you, my employer, attorney and/or insurance company, to pay directly to said Center such sums as may be due and owing them for medical services rendered to me and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said Center. They should also be paid any sum due them from any monies available through either Personal Injury Protection (PIP), health insurance, worker's compensation insurance, at this time. I hereby further give a lien on my case to said Center against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries or health condition for which I have been treated or injuries in connection herewith.

I fully understand that I am directly responsible to said Center for all medical bill submitted by them for services rendered me and that this agreement is made solely for said Center's additional protection and in consideration of them awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I understand that although most health insurances will cover the cost of chiropractic care at 80%, each policy may differ and it is my responsibility to check with my insurance carrier for details. I understand that AllCare Chiropractic will wait for payment for a reasonable period of time. If payment from an insurance company is not received in a timely fashion, I will be billed directly and will deal with the insurance carrier myself. If I am still awaiting a settlement on a personal injury case one year after reaching Maximum Medical Improvement or my last visit in this office, I will be required to begin making monthly payments equal to 10% of my outstanding balance at that time.

In the event legal action becomes necessary to collect any money due this office, the undersigned agrees to the entry of judgment in the amount equivalent to the unpaid balance plus interest at the rate of 18%, plus attorney/collection fees, and the undersigned waives any defense he/she may have as to the Statute of Limitations barring future attempts to recover debts owed hereunder in the event of default.

Dated:_____ Patient's Signature_____

Print_____

IF APLLICABLE:

The undersigned, being attorney of record for the above patient, do hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect AllCare Chiropractic.

Dated:_____ Attorney's Signature_____

- A photocopy of this form shall be considered as valid as the original.

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient:_____
Employer:_____
Claim/Group #_____
SS#/ID#_____

I hereby instruct and direct the _____Insurance Company to pay by check made out and mailed directly to:

AllCare Chiropractic, LLC
525 Main Street, Suite 105
Laurel, MD 20707

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O: _____
AllCare Chiropractic, LLC
525 Main Street, Suite 105
Laurel, MD 20707

The professional or medical expense benefits allowable, and otherwise payable to me under my current Insurance Policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at_____this_____day of_____, 20_____

_____ _____
Signature of policyholder Witness

_____
Signature of Claimant, if other than policyholder

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Financial Policy

The Doctors and staff of AllCare Chiropractic, LLC are very concerned about the cost of your healthcare and want to address some current issues related to the cost of chiropractic services in this office. It is a statement of our financial policy. Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise of your care. Our fees are comparable with the fees for similar services within the suburban Maryland area.

Please check off the box next to the areas that you have read and that apply to you at this time.

□ **Personal Pay**
- Payment is due at the time of service. We will accept payment in the form of CASH, CHECK, VISA, or MASTERCARD.
- Payment plans are available.

□ **Health Insurance**
- We will bill your insurance company on your behalf.
- If your insurance company requires a referral from your family doctor prior to being seen by a specialist, and one was not obtained, you will be billed by this office for services rendered.
- ***Your co-payment/coinsurance is to be paid by you at the time of each service.***
- Upon receipt of your statement, which shows the balance due by patient, PAYMENT IN FULL IS EXPECTED, unless you contact our office and make special payment arrangements. We are dedicated to working with you to assist you in keeping your account and credit in good standing. ***A monthly service charge of 1.5% for an annum of 18% of the total balance will be added to the outstanding balances after 30 days.***
- We will accept payment on your account in the form of CASH, CHECK VISA, or MASTERCARD. A returned CHECK will be charged a $35.00 overdraft charge.
- If you receive payment from your insurance company, that payment should be delivered to our office with the explanation of benefits report that accompanies the check.
- Failure or refusal to pay the full amount of your balance with our office may result in your account being referred for collection purposes. **In this event, you will be responsible for all pre-judgment interest at 18% per annum, reasonable collection costs, court cost and related fees, and post-judgment interest at the legal rate.**

□ **Medicare Coverage**
- We will bill Medicare for all services rendered. Medicare will cover 80% of spinal manipulation. Medicare does not cover exams, x-rays or physical therapy.
- If you have secondary or supplemental insurance, they may or may not pay for services not covered by Medicare.
- You are ultimately responsible for payments of all services rendered, deductible, and/or coinsurance.

□ **Workers' Compensation**
- We will bill the workers' compensation carrier and await payment for those on-the job accidents that have been reported and have not been disputed or denied. If for any reason payment of your claim is deferred or denied we require payment by you within 30 days.

□ **Auto Accidents/Liability (Slip and Falls)**
- We will bill the personal injury insurance of the vehicle you were in and your health insurance for payment of your bill. We will also bill the 3rd party if someone else was responsible for the accident and await payment of any amount not previously paid. We must have a signed lien by you and your legal counsel. Any PIP or health insurance payment will be applied directly to your account and will reduce the amount paid to us at time of settlement.

***Our Fees**—Some insurance companies reimburse based on arbitrary fee schedule and exclude various services as well. Our fees fall well within the usual and customary ranges reported by "Fee Facts" a national monitor of health care fees based on geographic location. It is not our policy to negotiate with your insurance company or pursue litigation to recover a fee, as the basic responsibility for payment is yours.

I have read, understand and agree to the above financial policies.

_____ _____

Patient or Responsible Party Signature **Date**

ALLCARE
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Laurel Historic Main Street
525 Main Street, Suite 105
Laurel, MD 20707
301-725-6884 Office
301-850-3333 Fax

Bowie Town Center
4345 Northview Drive
Bowie, MD 20716
301-464-5656 Office
301-850-3333 Fax

Silver Spring/White Oak
11231 Lockwood Drive
Silver Spring, MD 20901
301-289-7789 Office
301-850-3333 Fax

Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge that I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.
I intend this consent to apply to all my present and future chiropractic care.

Dated this_____ day of_____, 20_____.

_____ _____

Patient Signature (Legal Guardian) **Signature of Witness**

Name:_____ **Name:_____**
(Please print) **(Please print)**

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ☐ Provide and coordinate treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- ☐ Obtain payment from third-party payers for my health care services
- ☐ Conduct normal health care operations such as quality assessment and improvement actives

I have been informed of my provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient Name (Print): _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

For Office use only:

We were unable to obtain the patients written acknowledgement of our *Notice of Privacy Practices* due to the following reason:

- ☐ The Patient refused to sign acknowledgement
- ☐ Communication barriers
- ☐ Emergency Situation
- ☐ Other

NOTICE OF PRIVACY PRACTICES

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 Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists in the continuation of your care.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing treatment plans for your chiropractic services.

Health Care Operations include the business aspects of running our practice. For example, the patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgement in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by the written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.

The right to request an amendment to your protected health information. We may deny your request in certain situations.

The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations… or based on your previous authorization.

The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 1, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revision to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have that right to file a formal, written complaint with us at the address below, or with the department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
Dr. Jonathan C. Nou
ALLCARE CHIROPRACTIC, LLC
525 Main Street, Suite 105
Laurel, MD 20707
301-725-6884

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, SW
Washington, D.C. 20201
877-696-6775 (toll-free)