



TO THE

New Patient

OUTLINE OF PROCEDURES FOR CARE

STEP ONE:

All new patients are requested to fill out this personal health history questionnaire.

STEP TWO:

A one-on-one consultation with the doctor will be done to discuss your health problems and to determine what may be the cause.

STEP THREE:

A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

STEP FOUR:

The doctor will advise you if additional laboratory tests or x-rays if needed.

STEP FIVE:

You will be given a Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of our treatment recommendations and what results can be obtained. You will also be advised concerning how our office procedures work.

STEP SIX:

If you are accepted as a patient, care will begin. Additional explanations will be given on the different types of treatments that are available in the office.

STEP SEVEN:

An estimate of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of your problem has been obtained.

STEP EIGHT:

After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

DATE

I.D. NO.

PERSONAL HISTORY

Name: _____ Address: _____
 City: _____ State/Prov: _____ Zip/Postal Code: _____
 Home Phone: _____ Birth Date: _____ Age: _____ Sex: M F
 Cell Phone: _____ E-mail Address: _____
 Social Security # _____ Driver's License Number: _____
 Social Insurance # _____ Circle One: Married Single Widowed Divorced Separated
 Business Employer: _____ Type of Work: _____
 Business Phone: _____ Spouse's Social Security # _____
 Name of Spouse _____ Spouse's Social Insurance # _____
 Spouse's Employer _____ Business Phone _____
 Type of Work _____ Name and Ages of Children _____
 Referred To This Office By: _____
 Name and Number of Emergency Contact: _____ Relationship: _____
 Who Is Responsible For Your Bill, You and Spouse Workers' Comp. Auto Insurance Medicare Medicaid
 Personal Health Insurance (Name) _____ Health Card # _____
 Insured Person's Name _____ Date of Birth _____

CURRENT HEALTH CONDITION

Unwanted Health Condition _____
 Other Doctors Seen For This Condition: Yes No _____ Who? _____
 Type of Treatment: _____ Results: _____
 When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No
 Is Condition: Job Related Auto Accident Home Injury Fall Other: _____
 Date of Accident: _____ Time of Accident: _____
 Have You Made A Report of Your Accident To Your Employer: Yes No
 Drugs You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine
 Insulin Other _____
 Do You Wear A Shoe Lift? Yes No
 Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please Check and Describe:
 Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery
 Broken Bones Other _____
 Major Accident or Falls: _____
 Hospitalization (Other Than Above): _____
 Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema |

INTAKE

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

FEMALES ONLY:

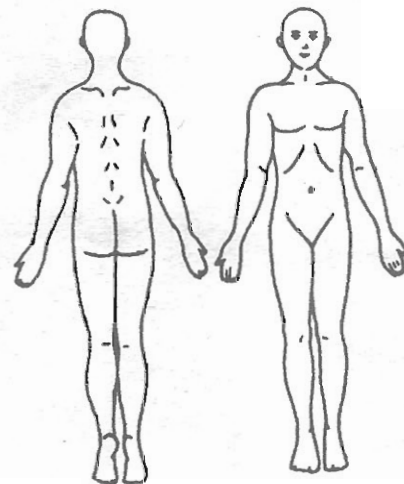
When was your last period? _____

Are you pregnant?

- Yes No Not Sure

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine



Please outline on the diagram the area of your discomfort

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____
- _____

FAMILY HISTORY

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: Yes No Referred

Doctor's Signature _____

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care

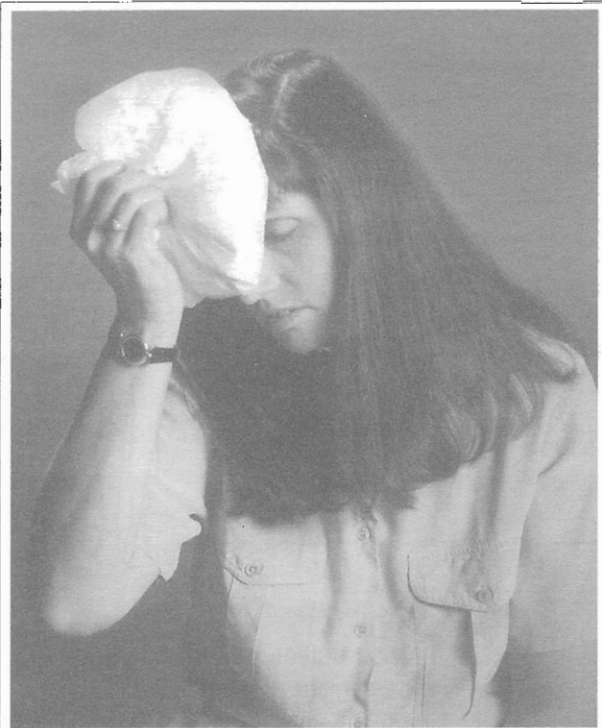
Corrective Care

Check here if you want the Doctor to select the type of care appropriate for your condition

Date

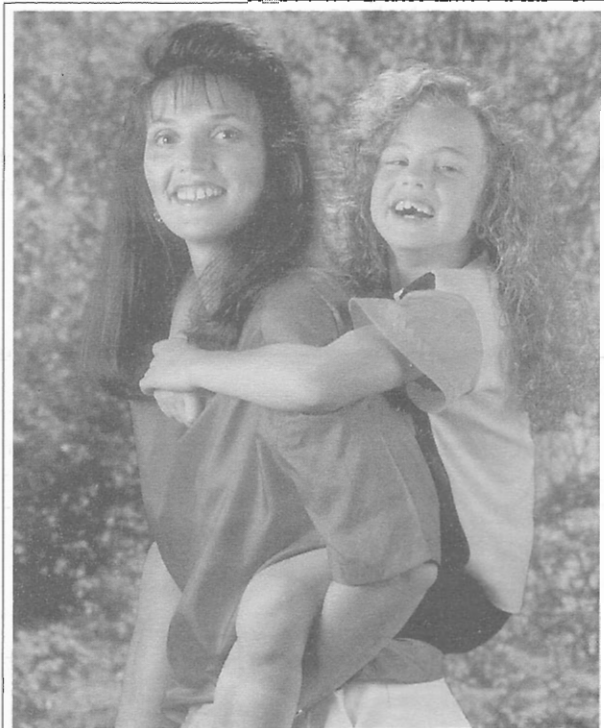
Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!



Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature _____

Date _____

Consent to Treat a Minor _____

Date _____

Guardian or Spouse's
Signature of Authorizing Care _____

Date _____

FIVE FORKS CHIROPRACTIC, PA

7 FIVE FORKS PLAZA COURT, SUITE D ♦ SIMPSONVILLE, SC 29681
PHONE (864)458-7008 ♦ FAX (864)458-7002 ♦ FIVEFORKSCHIRO@AOL.COM
DR. SUSAN M. MCDOWELL ♦ DR. HEATH BOST

Terms of Acceptance

I, _____, on this ____ day of _____, 20____, hereby give informed consent to Dr. Susan McDowell, Dr. Heath Bost, and appointed staff to provide chiropractic care and any supplemental therapeutic procedures deemed necessary by the doctor(s), from this day forward, until this relationship is terminated by Dr. McDowell, Dr. Bost or myself. I am aware that I may withdraw consent at any time by a verbal agreement between the doctor(s) and myself before care is given on any particular visit.

I give Dr. McDowell, Dr. Bost, or an appointed staff member, permission to examine my spine and take any necessary x-rays. I understand that I may be required to wear a gown during these procedures. I understand that I will be receiving adjustments on each visit, as determined by the doctor(s). I understand that an adjustment is a gentle force that is introduced into the spine or an extremity that helps the bone move back into its normal position.

I understand that chiropractic care is not a replacement for any medical care that I am currently receiving, or any care that I may require in the future. I understand that chiropractors do not engage in the practice of medicine, nor do they diagnose or treat symptoms and diseases. I also understand that chiropractic adjustments are given to remove subluxations and enhance health by removing interference to the nervous system. I understand that even though chiropractic care is not designed to treat symptoms or diseases, I may experience overall better health and/or decrease or absence of symptoms while I am receiving chiropractic care.

I have been informed that I may seek other types of care to treat any symptoms I may be experiencing, and it is my choice to become a chiropractic patient. Like other forms of treatment, I understand that chiropractic care has been associated with various incidents such as discomfort following an adjustment, as well as more serious incidents in rare cases.

With this informed consent, I may begin receiving chiropractic care. I have been informed that Dr. McDowell, Dr. Bost and staff will keep me informed about my progress while I am under care, and will answer any questions that I may have regarding my care.

X _____
Patient Signature

Date

X _____
Witness

Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

NOTICE OF PRIVACY
PRACTICES*

We Care About Your Privacy

FIVE FORKS CHIROPRACTIC, PA

7 Five Forks Plaza Court, Suite D
Simpsonville, SC 29681
(864) 458-7008

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

*These privacy practices are currently in effect and will remain in effect until further notice.

Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training

programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory:

Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification:

We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:

We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:

We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances:

We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:

To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:

Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:

We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:

As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:

We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if

it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:

We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:

We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:

Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:

We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services:

We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

Your Individual Rights

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.

2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.