GONSTEAD
CHIROPRACTIC CLINIC

Today's Date: ____/____/_____

Welcome to our office!

Last Name: _____ First Name: _____Middle Initial: ___

Height: _____ Weight: _____ Birth date: _____ Age: _____

Home Address: _____
(Street) *(City)* *(State)* *(Zip)*

Home Phone #: _____ Cell Phone #: _____

Employer: _____How Long: _____ Work #: _____

Occupation/Job Duties: _____

Spouse's Name: _____ Number of Children: _____

Emergency Contact (***name***): _____ (Phone #): _____

Have you received Chiropractic care before? □ Yes □ No

If yes, when and what condition? _____

How did you hear about our office? _____ Email: _____

Reason for visiting us today: _____

How and when did this begin? _____

What makes symptoms better? _____

What makes symptoms worse? _____

Rate the severity of your pain.

(***no symptoms***) 0 1 2 3 4 5 6 7 8 9 10 (***extreme pain***)

What is the type of your pain? (***check all that apply***)

□ Aching □ Burning □ Constant □ Dull
□ Numbness □ Other_____ □ Stabbing □ Throbbing

Is it constant or does it come and go? _____

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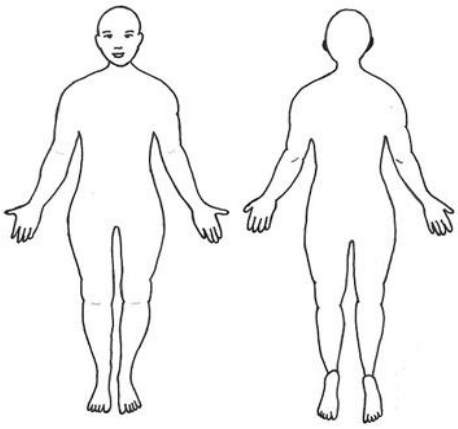
Patient History

Please indicate the location and type of pain on the figures below.



A = Ache
B = Burning
C = Constant
D = Dull
N = Numbness
O = Other _____
S=Stabbing
T=Throbbing

Health History *(please check all the apply)*

☐ Allergy Shots	☐ Emphysema	☐ Kidney Disorder	☐ Parkinson's
☐ Anemia	☐ Epilepsy	☐ Low back pain/stiffness	☐ Poor Circulation
☐ Arthritis	☐ Fibromyalgia	☐ Menstrual Cramps	☐ Reproductive Disorder
☐ Asthma	☐ Goiter	☐ Mid-back pain/stiffness	☐ Rheumatoid Arthritis
☐ Bladder Disorder	☐ Gout	☐ Migraines	☐ Shoulder Pain
☐ Cancer	☐ Headaches	☐ Multiple Sclerosis	☐ Sinus Trouble
☐ Chest Pain	☐ Heart Disorder	☐ Muscular Dystrophy	☐ Stroke
☐ Chronic Fatigue	☐ Hernia	☐ Neck Pain	☐ Thyroid
☐ Concussion	☐ Herniated Disc	☐ Numbness or tingling in arms	☐ Tumors
☐ Convulsions	☐ High Blood Pressure	☐ Osteoporosis	☐ Ulcers
☐ Diabetes	☐ High Cholesterol	☐ Other: _____	☐ Upper back pain/stiffness
☐ Digestive Disorder	☐ Hip Pain	☐ Pacemaker	

Broken Bones *(please explain)* _____

_____

_____

Surgeries/Hospitalizations *(please explain)* _____

_____

_____

Family Health History_____

_____

_____

Medication *(s)* _____

_____

_____

Other *(please explain)*_____

_____

_____

_____

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Insurance Information

Who is responsible for this account? _____

Relationship to patient: _____

Primary Insurance Company: _____ *(Provide Proof of Insurance)*

Group #: _____

Insured's name: _____ Birthdate: _____

Secondary Insurance Company: _____ *(Provide Proof of Insurance)*

Group#: _____

Insured's name: _____ Birthdate: _____

Assignment & Release of Insurance Information

I, the undersigned, certify that I (***or my dependent***) have insurance coverage with _____ and assign directly to Dr. Joshua A. Kolonick all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our office. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.

_____ _____ _____

Responsible Party Signature *Relationship* *Date*

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Chiropractic Informed Consent to Treat

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy; diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, 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 on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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 to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____Date: _____

Print Name of Guardian/Parent and Relationship to Patient: _____

Guardian/Parent Signature: _____ Date: _____

Doctor of Chiropractic Name: _____

Signature of Doctor of Chiropractic: _____ Date: _____

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Specific Authorization

Name: _____ DOB: _____
The patient identified above authorizes Gonstead Chiropractic Clinic, PC to use and/or disclose protected health information in accordance with the following: ***(Please check all that apply.)***

☐ I give permission to Gonstead Chiropractic Clinic, PC to use the following information, but not limited to: my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, "miss you" cards, holiday related cards, using a picture of your child on our wall, using an internal referral board, testimonials, newsletters, leaving voicemail, e-mail, posting your name on our Welcome Board.

☐ I understand that a sign in sheet is used as an office procedure to verify my presence in the office and that others see this information.

☐ If Gonstead Chiropractic Clinic, PC contacts me by phone, I give permission to leave a phone message on my answering machine or voice mail.

☐ I give permission for Gonstead Chiropractic Clinic, PC to contact my insurance carrier to verify my coverage if I have chosen to use this method as my primary method of payment for services rendered.

☐ I understand that there is a $25.00 fee for missed appointments or those not cancelled 24 hours in advance.

☐ By signing this form, you are giving Gonstead Chiropractic Clinic, PC permission to use and disclose your protected health information in accordance with the directives listed above.

Right to Revoke Authorization

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of the Gonstead Chiropractic Clinic. The written notice must contain the following information: Your Name, Social Security number, Date of Birth, the date of your request, a clear statement of your intent to revoke this authorization, and your signature. The revocation is not effective until the Privacy Official receives it.

You have the right to refuse to sign this authorization. If you refuse to sign this, Gonstead Chiropractic will not refuse to provide treatment.
Gonstead Chiropractic Clinic, PC, requests this authorization for its own use/disclosure of Protected Health Information. You have the right to inspect or copy this PHI to be used or/and disclosed.

Signature_____Date_____

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. In specific instances, we will disclose your personal health information with your signed authorization. (See "Specific Authorization" form.)

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain rights regarding your health record information, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to:

Privacy Officer- Dr. Joshua A. Kolonick, 1301 Shiloh Road, Suite 1310, Kennesaw, Ga 30144

☐ I have read and understand the Notice of Privacy Practices for Gonstead Chiropractic Clinic, P.C.

Name: _____

Signature: _____

Date: _____