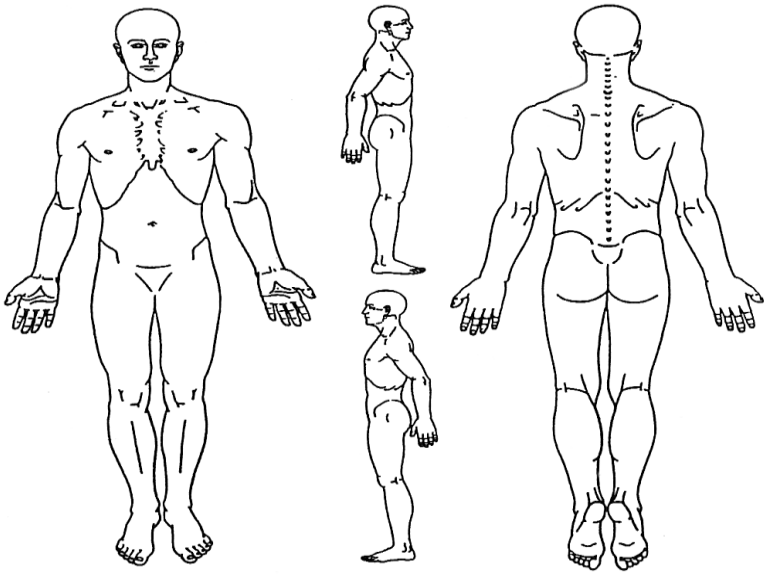
Name (please print): _____ **Date:** _____

General Pain Disability Index Questionnaire

Use the following letters to indicate the type & location of your sensations right now.

A= Ache N=Numbness P=Pins & Needles
B= Burning S=Stabbing O=Other



VBAI Questionnaire

Are you or have you recently experienced (within the past six months)

any of the following symptoms?

Dizziness, Vertigo or lightheadedness?	Yes	No
Drop Attacks or a loss of Consciousness?	Yes	No
Double Vision or visual problems?	Yes	No
Difficulty Speaking?	Yes	No
Difficulty Swallowing?	Yes	No
Difficulty Walking or using your extremities?	Yes	No
Nausea (with or without vomiting)?	Yes	No
Numbness on one side of the face or body?	Yes	No
Nystagmus (rythmical eye oscillation)?	Yes	No

Notice of Privacy Practices for Protected Health Information

HIPAA Policies and Procedures require that the regulations according to HIPAA Standards, applicable to the Chiropractic profession and in the state of Wyoming, be clearly posted within the office and made available to all patients upon written request.

I, the undersigned, have read the aforementioned paragraph and understand that I have the right to request a copy of the HIPAA Policies and Procedures at this office. I also understand that I have the right to amend my health care information (in writing) if I so desire.

Insurance, 3rd Party Payment , Medicare & Medicaid Policy

Integrity Chiropractic and Family Wellness, PC. is a cash based practice and prides itself in the highest quality of care available. In the best interest of our patients, we will not limit the quality of care in this office by the standards set by the insurance industry. Therefore, Integrity Chiropractic will not accept insurance or any other 3rd Party Payment program. We will, however, give you (the patient) a superbill at the end of each month to submit to your insurance company in order to be reimbursed by them directly.

Since Integrity Chiropractic is not a Medicare or Medicaid provider, we cannot accept these patients.

I, the undersigned, have read The Notice of Privacy Practices and The Insurance, 3rd Party Payment, Medicare and Medicaid Policy statements and understand Integrity Chiropractic and Family Wellness, PC is a cash based practice and will not bill my insurance carrier or other 3rd Party Payment program. I also understand that if I am under Medicare or Medicaid, I must pay 100% out of pocket to be treated in this office and that Medicare or Medicaid will **not** reimburse me for **any** services received.

Consent to Treat

I, the undersigned, give my permission to the office of Integrity Chiropractic and Family Wellness, PC, to Dr. Scot Thomas Anderson, and to the employees of this office, to treat my health concerns through the modalities of chiropractic and the modalities used in this office.

Sign: _____ **Date:** _____