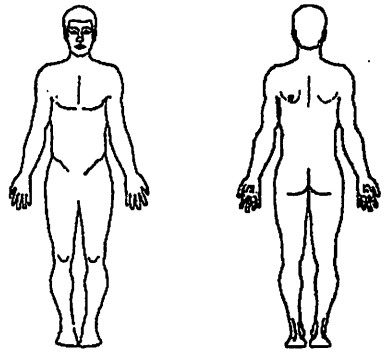
STEPHENS CHIROPRACTIC OFFICE 375 SW 32nd Street Okeechobee, FL 34974

HEALTH STATUS
Chiropractic

Patient Name _____ Birthdate _____ Sex: _____
Address _____ City _____
State _____ Zip _____ Phone _____ Patient Primary Language _____
Occupation _____ Employer _____ WorkPhone _____
Address _____ City _____ State _____ Zip _____
Subscriber Name _____ Health Plan _____
Subscriber ID# _____ Group # _____ Spouse Name _____
Spouse Employer _____ City _____ State _____ Zip _____
Primary Care Physician Name _____ PCP Phone _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other _____
Is this ? ☐ Work Related ☐ Auto Related ☐ N/A
Date Problem Began _____
How Problem Began _____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?)

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes
Date(s) taken _____ **What areas were taken?** _____

Please check all of the following that apply to you:

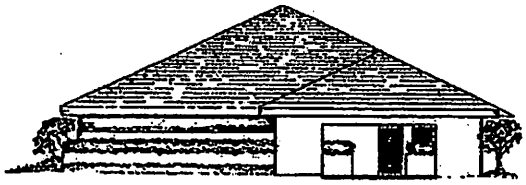
☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date) _____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain) _____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain) _____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries _____
☐ Tobacco use - Type _____
Frequency _____ /Day
☐ Medications _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature _____ **Date** _____



STEPHENS CHIROPRACTIC
375 S.W. 32nd Street
Okeechobee, FL 34974
Phone: (863) 763-0880
Fax: (863) 763-3077

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) but the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as a backup for the doctor of chiropractic named above, including those working at the clinic or office listed above or any other office. I have had the opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but no 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 on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts know, is my best interest.

I have read, and 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 any future condition(s) for which I seek treatment.

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the patient or legal guardian of_____
have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.
Date of last menstrual cycle: _____

MEDICARE CONSENT TO RELEASE INFORMATION

I certify that the information given by me in applying for payment under Title XVII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other carriers any information needed for this or related Medicare claim.

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions
- I authorize the release of information to all my insurance carriers and Doctors unless specified otherwise by me
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers
- I permit a copy of this authorization to be used in place of the original
- I authorize payment directly to my doctor
- I understand I am responsible for my bill
- I authorize the release of any medical or other information necessary to process this claim

_____ _____ _____

Patient Signature | Print Patient Name | Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

_____ _____
Patient Signature

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

PATIENT NAME:_____

SIGNATURE ON FILE

***I authorize use of this form on all my insurance submissions
***I authorize the release of information to all my insurance carriers and Doctors unless specified otherwise by me
***I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers
***I permit a copy of this authorization to be used in place of the original
***I authorize payment directly to my doctor
***I understand I am responsible for my bill
***I authorize the release of any medical or other information necessary to process all claims

PATIENT SIGNATURE_____ **DATE**_____

SUPPLEMENTAL INSURANCE (If Applicable)

☐ Copy of card in chart ☐ Copy of Driver's License in chart

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I waive the collection of unreimbursed medical charges on the above mentioned patient/family.

AUTHORIZED SIGNATURE_____

DATE_____