Patient Information

Name: _____	***Birth date***:_____
Address_____	***Your Employer***: _____
City/ST/Zip: _____	***Occupation***:_____
Cell Phone:(_____)_____	***Work Phone***: (_____)_____
Home Phone:(_____)_____	***Email Address:***___ _____
Spouse's name:_____	***Spouse's employer***:_____

Please tell us who referred you to Dr. Anderson:_____

Describe your problem:

_____

When did you first notice it?

_____

What drugs have you taken and who prescribed them?

_____

What other treatments have you received and who performed them?

_____

Has any treatment helped?_____(females)Are you pregnant?_____

List EVERY drug you NOW take and what it is for (including other illnesses):

_____

List EVERY surgery that you have had (including childhood and non-back surgeries):_____

_____

Please read this notice: *This information is provided for your understanding and to clarify the* ***financial policies*** *at Anderson Chiropractic. This way we can devote our efforts to helping you get the best results in the shortest amount of time.*

We accept cash, personal checks and Visa, MasterCard, Discover & American Express. Patients are responsible for full payment at the time of service. Any other payment arrangements must be pre-authorized.

If your care is covered by group insurance or a third party, we will supply statements, reports and other documents to help you receive benefits. Please remember that all professional services are rendered and charged to the patient receiving care, not the third party. In addition, we will not become involved in disputes with your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" and "not medically necessary" charges, etc., other than to supply factual information. Should x-rays be indicated, our office is equipped to take them. State law requires the originals remain permanent property of the office. Should you need copies for your primary care physician or for your personal use, we will gladly supply copies after a $20 prepayment is made to cover copy film and processing.

Any outstanding balances are billed monthly on the first of each month and are due 10 days after the invoice date. Returned checks are subject to a $10.00 fee. Balances unpaid for more than 60 days will accrue interest charges of $5 per month, plus any legal or collection fees.

I have read, understood, agreed to, and received a copy of this agreement.

_____	_____	_____
Patient/Guardian Signature	Date	Witness

Progress Report

Name:_____ **Date:**_____

Please mark the level of intensity of your symptoms using the following scale.
(0 equals no symptom at all, 100 equals maximum *possible* intensity of the symptom.)

Example: Symptom: Headache above my eyes

0 10 20 30 40 50 60 70 80 90 100

Symptom:_____
0 10 20 30 40 50 60 70 80 90 100

Symptom:_____
0 10 20 30 40 50 60 70 80 90 100

Symptom:_____
0 10 20 30 40 50 60 70 80 90 100

Symptom:_____
0 10 20 30 40 50 60 70 80 90 100

Symptom:_____
0 10 20 30 40 50 60 70 80 90 100

How much are your symptoms preventing you from doing what you would normally do during the day?
For each of the categories of daily living listed, mark the level which describes your typical level of activity.
(0 means no change in your level of function, 100 means you cannot function because of your symptoms.)

Family/Home (Chores around house/yard, taking kids to school, running errands, grocery shopping, etc.)
0 10 20 30 40 50 60 70 80 90 100

Recreation (Hobbies, sports, & leisure activities.)
0 10 20 30 40 50 60 70 80 90 100

Social Activity (Parties, theater, concerts, dining out, and other social functions, etc.)
0 10 20 30 40 50 60 70 80 90 100

Occupation (job related activities, including non-paying jobs such as homemaker or volunteer work.)
0 10 20 30 40 50 60 70 80 90 100

Self Care (taking a shower, getting dressed, etc.)
0 10 20 30 40 50 60 70 80 90 100

Life Support Activity (eating, sleeping, breathing,etc.)
0 10 20 30 40 50 60 70 80 90 100

_____
Patient Signature

Anderson Chiropractic

Privacy Notice

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Anderson Chiropractic we may use or disclose personal and health related information about you in the following ways:

*Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, email address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint in writing to:

Dr. Kevin L. Anderson, D.C.
1227 West Oak Street
Zionsville, Indiana 46077
317-873-1000

If you would like further information about our privacy policies and practices please contact:

Dr. Kevin L. Anderson, D.C.
1227 West Oak Street
Zionsville, Indiana 46077
317-873-1000

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients, guests and/or staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you.

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____
Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

_____ _____ _____
Personal Representative Printed Signature Date

_____
Description of the authority to act on behalf of the patient. (Parent/Guardian/etc.)