Last, First _____ DOB _____

Address _____

City, St _____

Zip Code _____

Are you eligible for Medicare?

YES ☐ NO ☐

Occupation _____

Home # _____

Cell # _____

How did you hear about this office? _____

Email _____

Unlimited CHIROPRACTIC

Terms of Acceptance

Chiropractic has only **one** goal and that is to remove nerve interference caused by a misalignment of spinal bones. It is important that you understand that diagnosing conditions, treating conditions and removing pain is **not** the objective of this office and that removing nerve interference through specific chiropractic care is the only goal of **Chiropractic** in this office. Although this office may relieve you of some pain, maintaining your health through regular spinal adjustments is our primary concern. All health care procedures carry some risk. Risks associated with chiropractic care may include, but are not limited to, muscle or ligament injuries, nerve or vascular injuries and fractures.

I therefore accept chiropractic care on this basis.

Signature_____Date_____

CHIROPRACTIC PRICES

ADJUSTMENTS $25

UNLIMITED ADJUSTMENT MEMBERSHIP

$59- Single
$79- Couple
$89- Family
(prices via auto-debit add $20 to pay for single month)
(includes one adjustment per day)
(50% off hydromassage)

PRE-PAID ADJUSTMENT PACKAGES

5 visits $115 = $23 each
10 visits $200 = $20 each
15 visits $270 = $18 each
20 visits $320 = 16 each
(never expires)
(can be used by anyone)
(Hydromassage discount $.50/minute)

HYDROMASSAGE PRICES

$1 per minute

Unlimited Hydromassage
$20/month
(includes 10 min daily)
(.50/min additional minutes)
(prices via auto-debit)
(add $10 to pay for single month)

Special!!! Adjustment & 10 minutes Hydro $30

Unlimited Chiropractic, LLC of Kokomo, Indiana
NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply to Unlimited Chiropractic, LLC (UC) of Kokomo, Indiana. All of the employees may share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new notice effective for all personal health information maintained by UC. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or Information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer, Amanda Jones, DC (UC) 200 N Washington, Kokomo, IN 46901.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not use or disclose your personal health Information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures for Treatment:

With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment, doctors and nurses and other professionals involved in your care will use Information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history etc. Uses and disclosures for payment: With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward Information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations:

With your agreement, we will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

Individuals Involved In Your Care:

With your written or oral agreement we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health Information with involved Individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be Involved in some aspect of caring for you.

Business Associates:

Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services:

We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from as by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request.

Other Uses and Disclosures:

We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- any purpose required by law.
- public health activities, *such* as required reporting of disease, injury, birth and death, or required public health investigations.
- if we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
- to your employer when we have provided health care to you at the request of your employer;
- to a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
- court or administrative ordered subpoena or discovery request;
- to law enforcement officials as required by law to report wounds and injuries and crimes;
- to coroners and/or funeral directors consistent with law;
- to workers' compensation agencies for workers' compensation benefit determination.

RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION:

Access to Your Personal Health Information

You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a Patient Access to Health Information Form" from the front office person.

Amendments to Your Personal Health information

You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/corredion request, If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Personal Health Information

You have the right to receive an accounting of certain disclosures made by us of your personal health information after Feb 11 v 2013. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forme are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Personal Health Information:

You have the right to request restrictions on uses end disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.

Complaints:

If you believe your privacy rights have been violated, you can file a complaint in witting with the Privacy Officer, Amanda Jones, DC 200 N Washington, Kokomo, IN 46901. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Workers' Compensation:

Medical Information generated for services provided to Workers' Compensation patients is not covered by HIPAA. As such, Worker's Compensation patients do not have the right to restrict, **amend** or request an accounting of their Personal Health Information generated for purposes of Worker's compensation.

FOR FURTHER INFORMATION:

If you have questions or need further assistance regarding this Notice, you may contact the Privacy Officer,
Amanda Jones, DC 200 N Washington St. Kokomo, IN 46901
Signature below is only acknowledgment that you have received our Notice of Privacy Practices.

Signature_____ Date_____

Patient History

Name_____

Reason for visiting us today_____

Have you ever received Chiropractic Care?_____

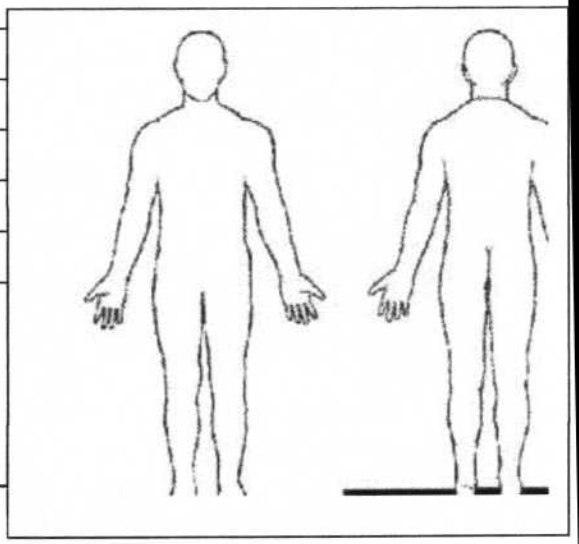
Have you been to hospital/doctor for this?_____

When and how did this begin? _____

Does anything make it better?_____

Does anything make it worse?_____

Please circle Problem Area



Rate the severity of your pain

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Type of Pain (Circle all that apply)

aching sharp shooting burning throbbing deep nagging other_____

Does this travel to any areas of your body? NO YES... If yes, where?_____

Is it constant or does it come and go?_____

HISTORY

☐ Headaches ☐ Neck Pain ☐ Migraines

☐ Upper back pain/stiffness ☐ Numbness in Hands or Arms ☐ Hip

☐ Shoulder pain ☐ Lower back pain/stiffness ☐ Other_____

Broken bones? If yes please explain _____

Surgeries? If yes, please explain _____

Hospitalizations_____

Current Medical Conditions_____

Past Medical Conditions _____

Family Health History_____

Medications/supplements_____

Other_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Signature _____ Date _____

Parent/Guardian Signature (if Applicable)_____ Date _____

Doctors Signature _____ Date _____

PATIENT PRIVACY, INFORMED CONSENT AND NON-BILLING STATEMENT

Requested Restrictions on Certain Disclosures of Health Information; In the case that an individual requests under paragraph (a)(1)(i)(A) of section 164.522 of title 45, Code of Federal Regulations, that a covered entity restrict the disclosure of the protected health information of the individual, notwithstanding paragraph (a)(1)(ii) of such section, the covered entity must comply with the requested restriction if:

- Except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operation and is not for purposes of carrying out health care services.
- The protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.
- I understand and am informed that some risks are associated with chiropractic adjustments, including, but not limited to, sprains, dislocations, fractures, disc injuries, strokes and paralysis.
- I give permission to Unlimited Chiropractic to use my address, phone number and clinical records to contact me with notifications, birthday cards, holiday related cards, information about treatment alternatives, or other health related information.
- If Unlimited Chiropractic contacts me by phone, I give them permission to leave a message on my answering machine or voicemail.
- I give Unlimited Chiropractic to provide chiropractic services in a room where the walls may not be 100% sound proof. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- I give Unlimited Chiropractic permission to access my patient care records in accordance with all applicable laws.

I, _____ (Patients Name) hereby direct that Unlimited Chiropractic shall not submit any billing data or related claims(s) for, or on, my behalf to any private insurance program, Medicare or any Secondary Medicare Insurance Program carrier with whom I have insurance coverage. I hereby acknowledge that I will be financially responsible to remit payment in full for all services provided to me at Unlimited Chiropractic. By signing this form you understand the informed consent and are giving permission to use and disclose you protected health information in accordance with the directives listed.

_____ _____

(Patient Signature) (Date)

_____

(Patient Printed Name)

_____ _____

(Witness Signature) (Date)