

CHIROPRACTIC REGISTRATION AND HISTORY



Patient Information

Date _____
SSN _____
Patient Name _____
Address _____
City/State/Zip _____
Email _____
Sex M F Age _____ Pregnant Y N
Date of Birth _____
Married Widowed Single Minor
Divorced Separated
Patient Employer/School _____
Occupation _____
Employer/School Address _____
Employer/School Phone Number _____
Spouse's Name _____
Date of Birth _____
Spouse's Employer _____
Whom may we thank for referring you? _____



Insurance Information

Responsible Party _____
Relationship to Patient _____
Insurance Co. _____
Policy Number _____
Subscriber Date of Birth _____
Subscriber's Name _____
Subscriber SSN _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to TOTAL LIFE CARE 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. The above named facility may use my information and disclose such information to the above named insurance company for the purpose of obtaining payment for services rendered.

Signature of Patient, Parent or Guardian _____

Print Name _____

Date _____



Phone Numbers

Cell Phone _____ Home _____
Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT
Name _____ Phone _____
Relationship _____



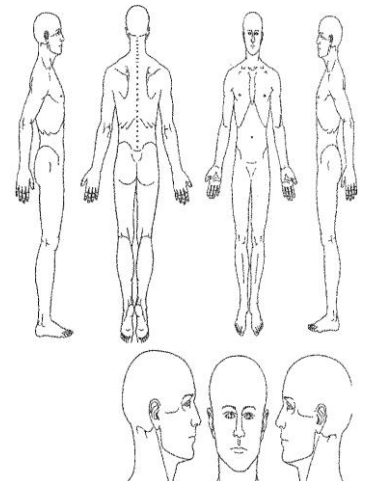
Accident Information

Is condition due to an accident? Y N
Date _____
Type of Accident _____
Bill to _____
Attorney Name _____



Patient Condition

Reason for visit _____
When did your symptoms appear? _____
Is the condition getting worse? Y N
Mark an X on the picture where you feel pain, numbness or tingling.
Rate the severity of pain on scale from 1 (least) to 10 (most severe) _____
Type of Pain: Sharp Burning Throbbing Tingling
How often do you have this pain? _____
Does it interfere with daily activities? _____ If so, what? _____
Does pain radiate? Yes No If so, where? _____





Health History

What treatment have you already received for your condition? Medication Surgery P. T.
 Chiropractic Services None Other _____

Name of other Doctor(s) who have treated you for this condition _____

Date of Last: Spinal Exam _____ MRI, CT Scan _____
Spinal X-ray _____ Urine Test _____
Blood Test _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | |
|---------------|--|------------------|--|-------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | R. A. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disc | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infection | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | M. S. | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fractures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | |

Exercise

- None
- Moderate
- Daily
- Heavy

Work Activity

- Sitting
- Standing
- Light Labor
- Heavy Labor

Habits

- Smoking Packs/Day _____
- Alcohol Drinks/Week _____
- Caffeine Cups/Day _____
- Stress Reason _____

Are you pregnant? Yes No If yes, Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls _____	_____	_____
Head Injuries _____	_____	_____
Broken Bones _____	_____	_____
Dislocations _____	_____	_____
Surgeries _____	_____	_____

Medications/Vitamins	Reason	Allergies
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Family History

	Arthritis	Blood Pressure	Cancer	Diabetes	Epilepsy	Other
Mother	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Father	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Sibling	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Sibling	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Other	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N



Activities of Daily Living

Problems

- Travel Y N
- Grooming Y N
- Yardwork Y N
- Exercising Y N
- Housework Y N

Description

- ie: Driving _____
- ie: Showering _____
- ie: Gardening _____
- ie: Running _____
- ie: Vacuuming _____

Height _____

Weight _____

Handedness Right Left



X- Ray Confirmation

This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge I am NOT pregnant, and I consent to radiographic pictures if necessary.

Patient Signature

Date

I certify that the information contained within this form is correct to the best of my knowledge.

Patient Signature

Date

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME _____ DATE _____

1. Do you suffer from neck pain with pain in your shoulder, arm or hands? NO YES
Comment: _____
2. Do you have weakness, numbness, or burning in your shoulder, arm, or hands? NO YES
Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
Comment: _____
5. Do you suffer from a loss of hand grip strength? NO YES
Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs, or feet? NO YES
Comment: _____
7. Do you have weakness, numbness, or burning in your buttocks, legs, or feet? NO YES
Comment: _____
8. Do your legs or feet fall asleep regularly? NO YES
Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs or feet? NO YES
Comment: _____
10. Do you suffer from cold hands or feet? NO YES
Comment: _____
11. Do you suffer from headaches, dizziness, or memory loss? NO YES
Comment: _____
12. Do you have difficulty maintaining your balance? NO YES
Comment: _____
13. Do you suffer from vertigo or blurred vision? NO YES
Comment: _____
14. Do you suffer from a reduced hearing capacity? NO YES
Comment: _____
15. Do you suffer from ringing in your ears? NO YES
Comment: _____
16. Do you have bladder or bowel control problems on a regular basis? NO YES
Comment: _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP
ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

TOTAL LIFE CARE CHARLESTON, LLC.
825 Wappoo Road
Charleston, SC 29407-7859

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

TOTAL LIFE CARE CHARLESTON, LLC.
825 Wappoo Road
Charleston, SC 29407-7859

for the professional or chiropractic expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photo copy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any Insurance company, adjuster, or attorney involved in this case.

Dated: _____ 20____.

Signature of policyholder*

Signature of Claimant, if other than Policyholder

*With my signature above, the full deductible or co-payment would be a financial hardship on me.

THIS FORM IS NOW REQUIRED BY THE UNITED STATES GOVERNMENT UNDER HIPAA REGULATIONS
Notice of Privacy Practices for Protected Health Information

- A. Uses and Disclosures
- B. Appointment Reminders
- C. Marketing
- D. Fund Raising

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.

A. Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1. Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3. Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4. Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.520(b)(1)(iii) (A). If you are not at home or work to receive an appointment reminder, a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

B. Appointment Reminders

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home or work, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

C. Marketing

From time to time our practice works with marketing organizations we will never use any information about you without your written approval. This form does not give that approval. If we ever decide to use information from or about you, another form detailing what information we want to use and for what purpose will be presented for your approval.

You have the right to refuse to give us authorization to contact you for marketing purposes. If you do not give us authorization it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to market products and/or services to you at any time. Our practice and staff will receive direct or indirect remuneration from our marketing activities.

D. Fund Raising

From time to time our practice works with charity organizations we will never use any information about you without your written approval. This form does not give that approval. If we ever decide to use information from or about you, another form detailing what information we want to use and for what purpose will be presented for your approval.

You have the right to refuse to give us authorization to contact you for fund raising purposes. If you do not give us permission, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you about fund raising efforts at any time. Our practice and staff will receive direct or indirect remuneration from our fund raising activities.

Our Privacy Pledge

We have an always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
2. We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3. We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4. We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain consent after attempting to do so.
5. We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples, any other use or disclosure of your health information will only be made with your written authorization.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization.164.508(b)(5)(I)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization please write to us at:
TOTAL LIFE CARE CHARLESTON, LLC 825 Wappoo Road, Charleston, SC 29407

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and /or copy your health information to be in writing.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except

- those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
- those disclosures made to you.
- those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- those disclosures for national security or intelligence purposes.
- those disclosures made to correctional officers or law enforcement officers.
- those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your right to obtain a paper copy of this notice If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

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

Your right to complain

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to: TOTAL LIFE CARE 825 Wappoo Road, Charleston, SC 29407

To contact us

If you would like further information about our privacy policies and practices please contact: TOTAL LIFE CARE CHARLESTON, LLC 825 Wappoo Road, Charleston, SC 29407

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I have read and understand the Patient Privacy Procedures of TOTAL LIFE CARE CHARLESTON, LLC

Patient Signature

Date

LETTER OF NO ACCIDENT OR INJURY

I hereby state with my signature that I was not involved in any auto accident, slip and fall, or work injury. My treatment is in no way associated with any 3rd party, and no other party is responsible or liable for the cost of my treatment.

Please process and pay all claims immediately to:

Total Life Care Charleston, LLC
825 Wappoo Road
Charleston, SC 29407

Sincerely,

Patient Signature

Date

Print Patient Name

Insurance Policy Number