Today's Date: _____

PHENIX CITY SPINE & JOINT CENTER

WELCOME

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell #: _____

Cell Phone Carrier: _____ Race: _____

Ethnicity: Hispanic Non Hispanic

Date of Birth: _____ Age: _____ SSN: _____

Employer: _____ Occupation: _____

Work Phone: _____ Email: _____

Marital Status: M S D W Spouse Name: _____

Insurance Information: Please give copy of the Insurance cards to the front desk.

Name of Insurance Co: _____

Policy #: _____ Group #: _____

Phone #: _____

Address: _____

If Using Spouse's Card
Their Date of Birth: _____ Spouse SS #: _____

Please list ALL medications

Name Of Medication	Dosage/ Strength	Frequency	Date Started

Known Allergies:

_____

_____

_____

Emergency Contact Information

Name: _____ Phone: _____

Name: _____ Phone: _____

Today's Date: _____

PHENIX CITY SPINE & JOINT CENTER

Please tell us:

What hurts? _____

_____

When did this happen? _____

How did this happen? _____

_____

_____

What have you done for the pain? _____

_____

Have you seen any other doctors for these issues? **Y** **N**

If yes, who did you see? _____

_____

What did they tell you? _____

_____

_____

Who is your Primary Care Physician:

_____

PCP Address:

_____

_____

PCP Phone:

_____

PCP Fax:

_____

Have you seen a Chiropractor before? **Y** **N**

Who was the Chiropractor? _____

What would you like us to do for you?

_____

_____

How did you find out about this office?

_____

Today's Date: _____

In detail, describe your pain and draw it on the figures below:

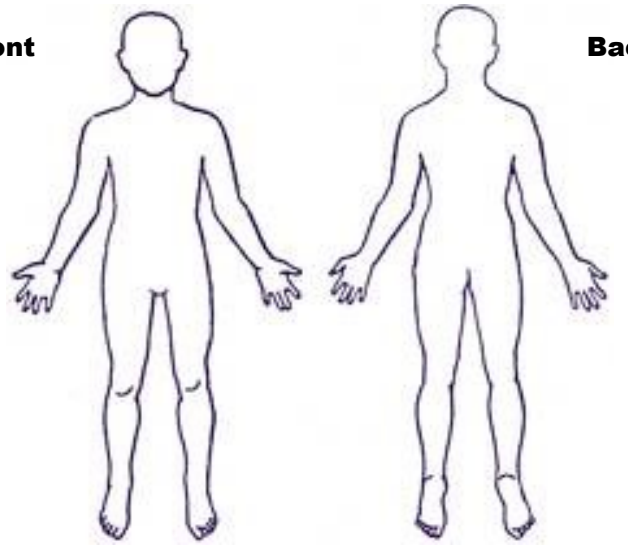
_____

_____

_____

_____

Front **Back**



Please label the areas of complaint and tell us if the pain is:

sharp, dull, burning, etc.

Is there anything else about your health you need to tell us?

_____

_____

List your current complaints in order of severity.

On a scale of 0 to 10 with 0 being NO PAIN and 10 being unbearable pain, rate each of your complaints listed.

What hurts the worst	Rate from 0—10	How & When does it hurt?

Past Health History

Have you been in an accident or had a major injury prior to today? Y N

Tell us about it: _____

_____

Are you pregnant? Y N

Please list in detail any previous hospitalizations:

_____

_____

Circle if you have or had: Sickle Cell Diabetes HIV Cancer

Osteoporosis Epilepsy Rheumatoid _____

Today's Date: _____

Consent for Treatment

I, _____ (Print Name), do hereby authorize Dr. Stephen B. Cooper and whomever he may designate as his assistants to perform diagnostic tests, including but not limited to radiographs, physical examination and administer treatment as directed, indicated or deemed necessary. This includes emergency actions that may need to be performed should I be physically incapacitated. Complications to chiropractic care may include rib fracture and stroke, however, specific tests designed to minimize these risks are employed and do minimize these outcomes. I ALSO CERTIFY THAT IN NO WAY HAS ANY GUARANTEE OR ASSURANCES AS TO THE RESULTS THAT MAY BE OBTAINED.

I understand and agree that health and medical insurance policies are an arrangement between an insurance carrier and myself (patient). Furthermore, I understand and agree that this office and contracted representatives may prepare or receive any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid and sent directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that I have sought treatment, received treatment, and am directly responsible for the bills that accumulate from this treatment.

Name Printed: _____ **Date:** _____

Name Signed: _____ **Date:** _____

Witness

Name Signed: _____ **Date:** _____

Consent for Treatment of a Minor

I hereby authorize the Phenix City Spine & Joint Center, LLC, Stephen B. Cooper, DC and whomever they may designate as an associate or contractor of this clinic to perform diagnostic tests, radiographic studies, physical evaluations, and to administer treatment as he deems necessary to _____, a minor child under my guardianship. I also accept all terms and conditions named herein with regards to payment of the account and lien arrangements and am responsible for the execution of these agreements on this minors behalf.

Parent / Guardian Signature

Name Printed: _____ **Date:** _____

Name Signed: _____ **Date:** _____

Witness

Name Signed: _____ **Date:** _____

Assignment of Benefits

I hereby authorize the following insurance companies or liable direct pay parties:

1. _____

2. _____

3. _____

4. _____

to pay by check or credit card through either mailing the check payable to Phenix City Spine & Joint Center—P.O. Box 1611 Phenix City, AL 36867. This covers the expense benefits allowable and otherwise payable to me under my current policy, as payment towards the total charges for professional services rendered I have agreed to pay, in a current manner, any balance of said applicable charges. I further state and agree that this office is given a limited power of attorney to endorse / sign my name on any and all drafts directed for the payment of my bill.

Patient

Name Signed: _____ **Date:** _____

Witness

Name Signed: _____ **Date:** _____

Today's Date: _____

HIPAA PRIVACY Statement for the PHENIX CITY SPINE & JOINT CENTER

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Understanding your health record information

Each time you visit a hospital, physician or other health care provider, a record of your visit is made. Typically this record contains your symptoms, examination, test results, diagnosis, treatment and a plan for future care and treatment. This information is often referred to as your health and medical record and serves as, but not limited to the following:

◊ A basis for planning your care and treatment

◊ Means of communication along the many health professionals who contribute to your care

◊ Legal documentation describing the care you received

◊ Means by which your third party payer can verify that services billed were actually provided

◊ A tool in educating health care providers

◊ A source of date for medical research

◊ A tool we utilize to assess, analyze and improve the care we render and the outcomes we have achieved.

This Information is shared with you to help you:

◊ Ensure its accuracy

◊ Understand who and under what circumstances they may access your health information

◊ Make a more informed decision when signing disclosure statements to authorize access by others.

Your Health Information Rights

Although your health record is the physical property of the health care provider or the facility who compiled it, the information belongs to you. You have the right to:

◊ Request a restriction on certain uses and disclosures of your information as provided by CFR 164.522

◊ Obtain a paper copy of notice of information practices upon request

◊ Inspect and copy your health record as provided in 45 CFR 164.524

◊ Amend your health record as provided in 45 CFR 164.528

◊ Obtain an account of the disclosures of your health record

◊ Revoke authorization for future disclosure except that which has already been provided

Our Responsibilities:

◊ Maintain privacy of your health information

◊ Provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you

◊ Abide by all the terms of this notice

◊ Notify you if we are unable to agree to a requested restriction

◊ Accommodate reasonable requests you may have to communicate health information by alternative means to alternative locations

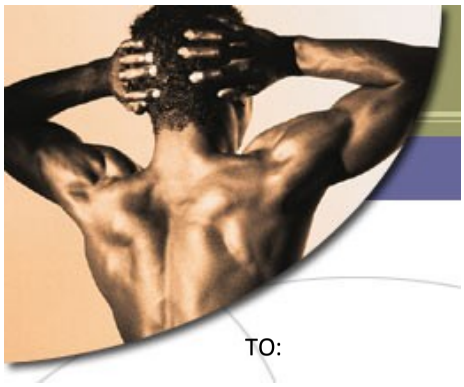
We reserve the right to change our practices and make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied to us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For more information, questions, or to report a problem, you may contact our HIPAA Privacy Officer at (412) 446-9100. If you believe your privacy rights have been violated, you may file a complaint with our HIPAA Privacy Officer. There will be no retaliation for filing a complaint.

I have read the HIPAA PRIVACY STATEMENT and Understand: _____ Initial

(HIPAA stands for the "health insurance portability and accountability act")



Phenix City Spine & Joint Center

Stephen B. Cooper, DC

3700 South Railroad St. Suite B

Phenix City, AL 36867 **334.298.7700 office / 334.298.7071 fax**

Today's Date: _____

TO:

_____

_____

_____

This is a formal request for medical records, x-ray's, MRI's, Lab Tests and reports be sent to Phenix City Spine and Joint Center to the above address or faxed to: 334-298-7071 regarding the patient:

Patient Name (printed)

_____

Social Security Number Birth date

_____ _____

Please send records by this date: _____

Patients Signature for Release:

_____ _____

Patient Signature Today's Date (request expires 30 days from this date)

If you have any questions, please call us at 334-298-7700. We appreciate your promptness for this request.

Thank You,

Phenix City Spine & Joint Center

Dr. Stephen B. Cooper