

Barnes Family Chiropractic

130 Canal St., Suite 603 | Pooler, GA 31322
Phone: (912) 748-3755 | Fax: (912) 748-3031

Application for Treatment

Date: _____

Name: _____ Nickname: _____

Address: _____

City: _____ State: _____ Zip Code _____ Email Address _____

SS#: _____ Age: _____ D.O.B. _____ Sex: _____

Marital Status: Single Married Divorced Widow Other: _____

Name of Spouse: _____ D.O.B. of Spouse _____

Phone # (H) _____ (W) _____ (Cell) _____

Occupation: _____ Employer: _____

Student? YES / NO Full Time Part Time Name of School: _____

Who referred you to this clinic? (Check one) Yellow Pages Friend Family Internet Doctor (Dr.'s Name) _____ Other: _____

Who is responsible for your bill? Self Health Insurance Employer Auto Insurance

Worker's Comp Other: _____

Health Insurance Info:

Name of Insurance: _____

Policy #: _____

Group #: _____

Insured's Date of Birth _____

Is this injury auto related?: YES / NO

Name of Insurance: _____

Policy #: _____

Claim #: _____

Secondary Insurance Info:

Name of Insurance: _____

Policy #: _____

Group #: _____

Insured's Date of Birth _____

-OR- Job related?: YES / NO

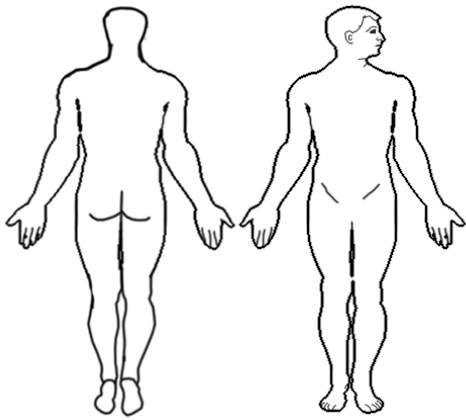
Name of Insurance: _____

Policy#: _____

Group #: _____

please continue on next page

PLEASE MARK EXACT LOCATION OF YOUR PAIN and describe your major complaints:



Check symptoms you have noticed:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Face flushed |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Balance |
| <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Upset stomach | <input type="checkbox"/> Constipated |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Fever | <input type="checkbox"/> Head seems heavy | |
| <input type="checkbox"/> Balance Changes | | | |

Symptoms other than above: _____

How did this condition develop?: _____

When were you first aware of this problem? _____

Have you ever had this or a similar problem before? If yes, when, where and what were results: _____

Has your condition been getting better, worse or staying the same: _____

How has this affected your home life: _____

Occupation: _____ Recreation: _____

Rest & Sleep: _____

Have you lost any days from work due to this condition? If yes, dates: _____

Any accidents or falls that might have caused your problem? If yes, date: _____

Have you had any back or spinal surgery I should be aware of?: _____

What previous surgery has been done?: _____

Is there a possibility of pregnancy at this time?: YES / NO Do you have a pacemaker?: YES / NO

Are you taking: Nerve pills Pain killers Muscle relaxers Tranquilizers Insulin Birth control

Others: _____

Do you have high or low blood pressure?: _____ Any heart problems?: _____ Aneurysms: _____

Phlebitis: _____ HIV: _____ Chiropractors consulted in the past?: YES / NO If so, Name: _____

Fees are payable at time of x-rays, examinations, and treatments are received unless other arrangements are made in advanced. Records remain the property of this clinic.

Signature: _____ **Date:** _____

Please read the following information regarding contraindications.
Notify the doctor if any of these conditions apply to you.

If you are unsure, please ask!!

The use of these machines is for symptomatic relief of chronic, intractable pain, muscle spasms and joint contractures.

Electrical Stimulation Contraindications:

- Demand type cardiac pacemakers
- Use over cancerous lesions

Ultrasound Contraindications:

- An area of the body where a malignancy is known to be present
- An acute infection or sepsis
- Pregnancy
- Deep Vein thrombosis (DVT)
- Arterial Disease
- An anesthetized area or condition that causes impairment of sensation, such as chemotherapy
- Cardiac pacemaker
- A healing fracture
- Ischemic tissue in individuals with vascular disease where the blood supply would be compromised
- Any metal in the body

I, _____, have read the above statement and to the best of my knowledge do not have any of the above listed contraindications to the use of the electric stimulation and ultrasound equipment.

Signature

Date

Authorization to Release Patient Records

I hereby authorize Barnes Family Chiropractic, 130 Canal Street, Suite 603, Pooler, Georgia 31322, to release a copy of my patient records or x-rays containing protected health information to

This authorization is given pursuant to Georgia Statue 31-33 and HIPAA regulations. I understand that Georgia Statute 31-33, makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without expressed written consent of the patient or the patient's legal representatives.

Please Check:

- All office notes, tests ordered or performed including labs, x-rays, etc by physicians office for all dates of service
- All records of testing and/or consultations performed or ordered by another physician or facility
- All records related to any psychiatric/mental illness and treatment(s) rendered
- All records related to diagnosis, testing and treatment of any sexually transmitted disease, to include HIV and AIDS

(Print name of patient)

(Patient's Date of Birth)

(Signature of patient or patient's legal representative)

(Date signed)

This authorization will expire on: _____ / _____ / _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.-

I understand that this form will be placed in my patient chart and maintained for six years.

(Print name of patient)

(Date signed)

(Signature of patient or patient's legal representative)

(Print name if other than patient)

Barnes Family Chiropractic

130 Canal St., Suite 603 | Pooler, GA 31322
Phone: (912) 748-3755 | Fax: (912) 748-3031

Assignment of Benefits Form

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICE RENDERED, TO INCLUDE BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OR BENEFITS/AUTHORIZATION TO PAY.

Known by all these present that: the undersigned has made, constituted and appointed, and by these present, does hereby make, constitute and appoint **Barnes Family Chiropractic, Inc.** and any of its duly authorized agents and employees as and to be the undersigned's true drafts or money orders which are made payable to the undersigned alone or to the undersigned and **Barnes Family Chiropractic, Inc.** which checks, drafts or money orders are made payable for services which have been made by **Barnes Family Chiropractic, Inc.**, at the request of with the knowledge and approval of the undersigned and/or maker of the check, draft or money order.

This assignment includes but is not limited to, all rights to collect benefits directly from my insurance company for services that I have received and all rights to proceed against my insurance company in any action including legal suit if for any reason my insurance company fails to make payments of benefits due to my assignee or me. If the insurance carrier fails to pay the full amount of benefits, as alleged and billed by **Barnes Family Chiropractic, Inc.**, I hereby instruct the insurance carrier to hold such amounts in escrow and not disperse such amounts until the dispute is resolved. This assignment also includes any rights to recover attorney's fees and costs for such action brought by the provider as my assignee.

The undersigned by these presents does give and grant **Barnes Family Chiropractic, Inc.**, as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as to fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said check and concerned as well as any other documents.

A photocopy of this document shall be binding as an original signature page.

The undersigned hereby does ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which they said attorney shall do cause to be done by virtue of their presents.

Assignment of Benefits

I, _____, hereby authorize _____
(Name of insured) (Name of Insurance company)

to pay to and mail directly to **Barnes Family Chiropractic, Inc.** the medical and personal injury protection benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby irrevocably assign to **Barnes Family Chiropractic, Inc.** my rights and benefits under any policy insurance, indemnity agreement, or any other collateral source as defined in Georgia Statutes for any services and charges provided by **Barnes Family Chiropractic, Inc.**

PATIENTS SIGNATURE

PATIENTS NAME (printed)

Date

Barnes Family Chiropractic

130 Canal St., Suite 603 | Pooler, GA 31322
Phone: (912) 748-3755 | Fax: (912) 748-3031

Consent to disclose medical information

Patient Name: _____ Date of Birth: _____

Please check ONE of the following:

I give my permission to the employees of Barnes Family Chiropractic to disclose my Protected Health Information to me and the following friends or family:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

-OR-

I request that all of my Protected Health Information be disclosed ONLY to me and no other family or friends.

I understand that I may revoke or change this consent at anytime by filling out another consent form to replace this one.

(Patient Signature)

(Date)

Barnes Family Chiropractic

130 Canal St., Suite 603 | Pooler, GA 31322
Phone: (912) 748-3755 | Fax: (912) 748-3031

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW THIS NOTICE CAREFULLY

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient confined or to a patient's home where the patient is to be examined or treated.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purpose of:

- (a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.
 - (b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing services, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell you insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.
 - (c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.
1. The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:
- (s) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.
 - (b) Business Associate - To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.
 - (c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
 - (d) Emergency Situations -
 - (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

- (ii) to a public entity authorized by law or buy its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
- (e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.
- (f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.
- (g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure; if the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.
- (h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigation, disciplinary actions, or general oversight activities relating to the communities health care system.
- (i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI to a court or a lawfully issued subpoena.
- (j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.
- (k) Coroner or Medical Examiner - The Practice may disclose you PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
- (l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
- (m) Research - If the Practice is involved in research activities, your PHI may be used, but such is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.
- (n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such a disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
- (o) Worker's Compensation - If you are involved in a Worker's Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Worker's Compensation system.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

SIGN-IN LOG

The Practice maintains a sign-in log for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, other who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment of your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, or your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.
- (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written authorization.

YOUR RIGHTS

1. You have the right to:

- (a) Revoke any Authorization and/or Consent, in writing, at any time and to request a revocation, you must submit a written request to the Practice's COMPLIANCE OFFICER.
- (b) Request restrictions on certain use and/or disclosure of your PHI as provided by law, however, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's COMPLIANCE OFFICER. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.
- (c) Receive confidential communications or PHI by alternative means or at alternative locations; you must make your request in writing to the Practice's COMPLIANCE OFFICER. The Practice will accommodate all reasonable requests.
- (d) Inspect and obtain a copy your PHI as provided by law. To inspect and copy your PHI, you are requested to submit a written request to the Practice's COMPLIANCE OFFICER. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.
- (e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's COMPLIANCE OFFICER. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.
- (f) Receive an accounting of disclosures of your PHI as provided by law. The request should indicate in what form you want the list (such as a paper or electronic copy)
- (g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's COMPLIANCE OFFICER.
- (h) Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202/619-0257, email: ocrmail@hhs.gov or to the Florida Attorney General, Office of the Attorney General, PL-01 The Capitol, Tallahassee, FL 32399-1050, 850/414-3300, if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's COMPLIANCE OFFICER. All complaints must be in writing.

- (i) To obtain more information on, or have your questions about your rights answered, you may contact the Practice's COMPLIANCE OFFICERS, Frankie Barnes or Wanda Barnes, at (912) 748-3755.

PRACTICE REQUIREMENTS

1. The Practice:

- (a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practices legal duties and privacy practices with respect to your PHI.
- (b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the following State statutes:
Section 31-33
- (c) Is required to abide by the terms of this Privacy Notice.
- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions for all of your PHI that it maintains.
- (e) Will distribute any revised Privacy Notice to you prior to implementation.
- (f) Will not retaliate against you for filing a complaint.

QUESTIONS AND COMPLAINTS

You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below who is the COMPLIANCE OFFICER and Contact person appointed for this practice. The COMPLIANCE OFFICERS are Christopher Barnes, and Wanda Barnes.

You may file a complaint with the COMPLIANCE OFFICER if you believe that your privacy rights have been violated relating to release of your protected health information. You may also submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the COMPLIANCE OFFICER. We will not retaliate against you in any way if you file a complaint.

EFFECTIVE DATE

This notice is in effect as of **November 14, 2011**