

WELCOME TO BROWER CHIROPRACTIC CENTER !

PATIENT INFORMATION

DATE: _____
FIRST NAME _____ MIDDLE INITIAL _____
LAST NAME _____
CALLED NAME / NICKNAME _____
ADDRESS _____ SUITE OR APT # _____
CITY _____, STATE _____ ZIP _____
HOME PHONE _____ WORK PHONE: _____ EXT _____
CELL PHONE _____ (OPTIONAL)
E-MAIL _____@_____ (OPTIONAL)
GENDER (PLEASE CIRCLE ONE) MALE FEMALE
MARITAL STATUS (PLEASE CIRCLE ONE) SINGLE MARRIED OTHER _____
DATE OF BIRTH ____/____/____
SOCIAL SECURITY # ____/____/____
DRIVERS LICENSE NO. _____ STATE _____
WORK STATUS (PLEASE CIRCLE ONE) EMPLOYED FULL TIME STUDENT PART TIME STUDENT

REFERRED BY: _____ PATIENT/FRIEND/RELATIVE (NAME : _____)
____ INSURANCE NETWORK _____ PHONEBOOK _____ SMARTPAGES (ONLINE) _____ WEB MD
____ DR BROWERS WEBSITE _____ OTHER WEBSITE (PLEASE SPECIFY: _____)
____ SIGN OUT FRONT _____ OTHER (PLEASE SPECIFY: _____)
____ PREVIOUS PATIENT

INSURED INFORMATION

PATIENT'S RELATION TO INSURED: SELF CHILD HUSBAND WIFE OTHER
IF OTHER THAN SELF, PLEASE COMPLETE:
FIRST NAME _____ MIDDLE INITIAL _____
LAST NAME _____
SOCIAL SECURITY # ____/____/____
DATE OF BIRTH ____/____/____
GENDER MALE FEMALE

EMPLOYER INFORMATION OF THE INSURED/INSURANCE

EMPLOYER'S NAME _____
ADDRESS _____
CITY, STATE, ZIP _____
PHONE _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ Date _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight?

Height

--	--	--

Feet Inches

Weight

--	--	--

 lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

- | <i>Past</i> | <i>Present</i> | <i>Past</i> | <i>Present</i> |
|-----------------------|--|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> Headaches | <input type="radio"/> | <input type="radio"/> High Blood Pressure |
| <input type="radio"/> | <input type="radio"/> Neck Pain | <input type="radio"/> | <input type="radio"/> Heart Attack |
| <input type="radio"/> | <input type="radio"/> Upper Back Pain | <input type="radio"/> | <input type="radio"/> Chest Pains |
| <input type="radio"/> | <input type="radio"/> Mid Back Pain | <input type="radio"/> | <input type="radio"/> Stroke |
| <input type="radio"/> | <input type="radio"/> Low Back Pain | <input type="radio"/> | <input type="radio"/> Angina |
| <input type="radio"/> | <input type="radio"/> Shoulder Pain | <input type="radio"/> | <input type="radio"/> Kidney Stones |
| <input type="radio"/> | <input type="radio"/> Elbow/Upper Arm Pain | <input type="radio"/> | <input type="radio"/> Kidney Disorders |
| <input type="radio"/> | <input type="radio"/> Wrist Pain | <input type="radio"/> | <input type="radio"/> Bladder Infection |
| <input type="radio"/> | <input type="radio"/> Hand Pain | <input type="radio"/> | <input type="radio"/> Painful Urination |
| <input type="radio"/> | <input type="radio"/> Hip/Upper Leg Pain | <input type="radio"/> | <input type="radio"/> Loss of Bladder Control |
| <input type="radio"/> | <input type="radio"/> Knee/Lower Leg Pain | <input type="radio"/> | <input type="radio"/> Prostate Problems |
| <input type="radio"/> | <input type="radio"/> Ankle/Foot Pain | <input type="radio"/> | <input type="radio"/> Abnormal Weight Gain/Loss |
| <input type="radio"/> | <input type="radio"/> Jaw Pain | <input type="radio"/> | <input type="radio"/> Loss of Appetite |
| <input type="radio"/> | <input type="radio"/> Joint Swelling/Stiffness | <input type="radio"/> | <input type="radio"/> Abdominal Pain |
| <input type="radio"/> | <input type="radio"/> Arthritis | <input type="radio"/> | <input type="radio"/> Ulcer |
| <input type="radio"/> | <input type="radio"/> Rheumatoid Arthritis | <input type="radio"/> | <input type="radio"/> Hepatitis |
| <input type="radio"/> | <input type="radio"/> General Fatigue | <input type="radio"/> | <input type="radio"/> Liver/Gall Bladder Disorder |
| <input type="radio"/> | <input type="radio"/> Muscular Incoordination | <input type="radio"/> | <input type="radio"/> Cancer |
| <input type="radio"/> | <input type="radio"/> Visual Disturbances | <input type="radio"/> | <input type="radio"/> Tumor |
| <input type="radio"/> | <input type="radio"/> Dizziness | <input type="radio"/> | <input type="radio"/> Asthma |
| | | <input type="radio"/> | <input type="radio"/> Chronic Sinusitis |
-
- | <i>Past</i> | <i>Present</i> |
|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> Diabetes |
| <input type="radio"/> | <input type="radio"/> Excessive Thirst |
| <input type="radio"/> | <input type="radio"/> Frequent Urination |
| <input type="radio"/> | <input type="radio"/> Smoking/Use Tobacco Products |
| <input type="radio"/> | <input type="radio"/> Drug/Alcohol Dependence |
| <input type="radio"/> | <input type="radio"/> Allergies |
| <input type="radio"/> | <input type="radio"/> Depression |
| <input type="radio"/> | <input type="radio"/> Systemic Lupus |
| <input type="radio"/> | <input type="radio"/> Epilepsy |
| <input type="radio"/> | <input type="radio"/> Dermatitis/Eczema/Rash |
| <input type="radio"/> | <input type="radio"/> HIV/AIDS |
-
- Females Only**
- | | |
|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> Birth Control Pills |
| <input type="radio"/> | <input type="radio"/> Hormonal Replacement |
| <input type="radio"/> | <input type="radio"/> Pregnancy |
| <input type="radio"/> | <input type="radio"/> |
-
- Other Health Problems/Issues**
- | | |
|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> |

Indicate if an immediate family member has had any of the following:

- Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

List all the surgical procedures you have had and times you have been hospitalized:

Patient Signature _____ Date _____

Doctor's Additional Comments

Doctors Signature _____ Date _____

BROWER CHIROPRACTIC INSURANCE FINANCIAL POLICY AGREEMENT

PARTICIPATING INSURANCE COVERAGE: I understand that I am responsible for the entire balance of my bill, although Brower Chiropractic will extend credit for the portion which is expected to be covered by insurance. Therefore I clearly understand and agree to the following:

- To pay in full until my yearly deductible is met (if applicable).
- To pay my copay percentage of the billed service(s) each visit (if applicable).
- To pay my flat copay per visit according to the copay provisions of my policy (if applicable).
- To pay the balance due on each claim after the receipt of any insurance payment, upon notification from this office. For plans in which we participate, this could include non-covered/patient responsible indicated service(s). Any credit balance will be applied to my active patient account. In the case my account is inactive, credit balances will be directly refunded to me.
- Dr. Brower makes every effort to ensure quality care is given, which may include after hours/weekend calls, for these visits there is a separate \$50 charge. This charge is usually not covered by insurance and therefore must be paid by the patient. It will be billed and if your insurance pays any portion you will receive a credit on your account.
- For any appointment missed or broken without at least a two hour notice a \$20 fee will be charged. This charge is NOT covered by insurance and will NOT be billed to any insurance company.
- If you have an HMO policy that requires a referral from a primary care doctor it is YOUR responsibility to obtain proper referral/authorization. We will be happy to assist you if needed, but will not be responsible if payment is denied for missing referral.
- If for any reason you have a balance due, you will receive a monthly patient statement. If you have a zero patient balance you will not receive any statement.
- A 1.5% monthly finance charge will accrue on all patient accounts over 30 days past due.
- If you have any questions regarding these guidelines, please ask. We are here to help you!

ASSIGNMENT, AUTHORIZATION AND POLICY STATEMENT

I HEREBY ASSIGN THE BENEFITS THAT I AM ELIGIBLE TO RECEIVE FOR THE CARE RENDERED IN THIS OFFICE, TO THE OFFICE. IN CONSIDERATION OF THIS ASSIGNMENT, THE OFFICE EXTENDS CREDIT. I AUTHORIZE THE OFFICE TO RELEASE ANY INFORMATION, PER HIPPA GUIDELINES, TO ANY INSURANCE COMPANY, ADJUSTER, OR ATTORNEY THAT WILL ASSIST IN THE PAYMENT OF CLAIM(S). I FULLY UNDERSTAND AND AGREE THAT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AND INSURANCE CARRIER AND MYSELF. I WILL BE RESPONSIBLE FOR ANY EXPENSES NOT PAID BY INSURANCE.

A PHOTOCOPY OF THIS FORM SHALL BE CONSIDERED AS VALID AS THE ORIGINAL. BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO THIS POLICY.

Patient Signature:

Date:

Patient Printed Name:

HIPAA Notice of Privacy Practices

Brower Chiropractic Center
6009 Falls of Neuse Road
Raleigh, N.C. 27609
919-876-9472

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for chiropractic care may require that your relevant protected health information be disclosed to the health plan, insurance carrier, HMO, PPO, or your employer, if they are responsible, to obtain approval for the care.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to other professionals that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment and to notify of office fundraisers and special offers or information on treatment alternatives or other health related information that may be of interest to you. This includes using your name, address, phone number and clinical records to contact you by mail or phone, if you are not able to receive a call, a message will be left on your answering machine.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____