

W CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank You.

E Name _____ Social Security # _____
Address _____ City _____ State _____ Zip _____
Home Telephone _____ Work Telephone _____

(Please complete if you are a part-time local resident.)

Address _____ City _____ State _____ Zip _____

Age ____ Male Female Birth date _____ # of children _____

Marital Status: M S W D Employer _____ Occupation _____

Spouse's Name _____ Spouse's Office Telephone _____

Referred by _____ Nearest Relative & Telephone _____

L HEALTH INFORMATION

Have you had previous chiropractic care? _____

What is your major physical concern? _____

Other symptoms of concern: _____

Onset of condition(s): _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? Yes No

What activities aggravate this condition? _____

Has this condition been getting progressively worse? Yes No

Constant Comes and goes

Has it been interfering with your: Work? Sleep? Daily Routine? Other _____

Do other family members have similar problems? Yes No

Please list _____

Other doctors who treated this condition _____

List surgical operations and years: _____

Drugs you now take: Nerve Pills Pain Killers Muscle relaxers

Insulin Birth control pills "Pep" pills

Tranquilizers Other _____

Age of mattress _____ Comfortable Uncomfortable

Are you wearing: Heel lifts Sole lifts

Arch supports Inner Soles

Have you been in an auto accident? Never Past year

Past 5 years Over 5 years

Describe: _____

Have you had any personal injury or accident? Never Past year

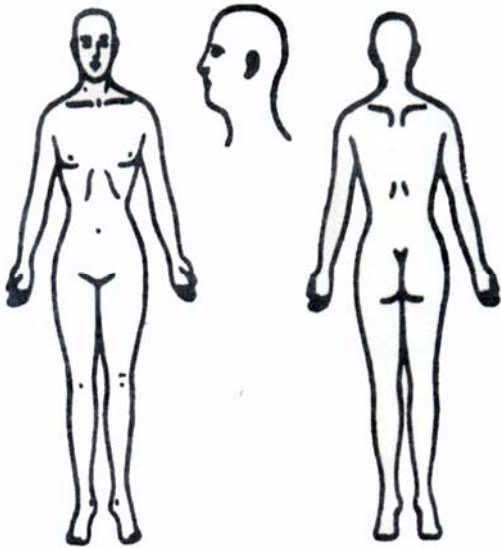
Past 5 years Over 5 years

Describe: _____

Date of last Physical Examination: _____

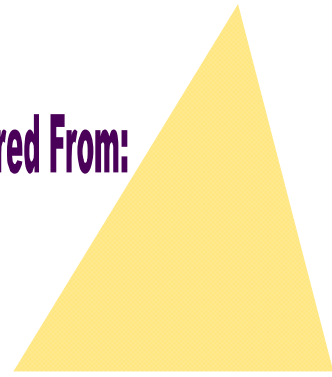
please turn over...

Please mark your areas of pain on the figures below.



Have You Ever Suffered From:

- ___ Dizziness
- ___ Backaches
- ___ Heart Trouble
- ___ Diabetes
- ___ Arthritis
- ___ Headaches
- ___ Asthma
- ___ Neuritis
- ___ Digestive Disorders
- ___ Nervousness
- ___ Sinus Trouble
- ___ Neck Pain



INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury? Yes No

Do you have Health Insurance? Yes No

Name of Insurance Company _____ Policy # _____

Insured's name _____ Date of Birth of the Insured _____

Insured's employer _____

Are you covered by Medicare? Yes No

If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I will be paying today by Cash Check Credit Card/ Card # _____

MasterCard Visa American Express Exp. Date _____

All accounts not paid within 90 days will automatically be put through on your credit card.

Patient's Signature: _____ Date _____

Guardian or Spouse's Signature: _____ S.S. # _____

Doctor's Signature: _____

FAMILY HEALTH INFORMATION

(Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better idea of your total health picture)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HIPAA Notice of Privacy Practices

I
Accurate Chiropractic LLC
9400 Gladiolus Drive Suite 20
Fort Myers, Florida 33908
(239) 481-8811

THIS NOTICE DESCRIBES HOW 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 a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

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, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. 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.

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 _____