Delmarva Chiropractic P.C.
1324 Belmont Ave Ste 102, Salisbury, MD 21804
Dr. Daniel G.J. Lane 410-219-5155 Dr. David R. Brown

ABOUT YOU

Today's Date: _____
Full Name: _____
Prefer to be called: _____
Address: _____
_____
City: _____
State: _____ Zip: _____
SSN: _____-_____-_____
Birth Date: _____/_____/_____ Age: _____
Gender: ❑ Male ❑ Female

Home Phone: (_____)_____
Cell Phone: (_____)_____
Employer: _____
Employer's Address: _____
City/State/Zip: _____
Work Phone: (_____)_____
Occupation: _____
Do you prefer to receive calls at: ❑ Cell ❑ Home ❑ Work
Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Separated ❑ Divorced
Email address: _____

1. Have you ever been to a chiropractor before? ❑ No ❑ Yes
   If so, explain? _____
2. Have you seen any other providers for this condition? ❑ No ❑ Yes If so, who: _____
3. Have you had any Imagining done? ❑ No ❑ Yes If so, where: _____
4. How did you hear about our office? ❑ Ins. Company ❑ Friend/Relative – If so who: _____
   ❑ Yellow Pages ❑ Other: _____

IN EVENT OF EMERGENCY

Who Should We Contact? _____ Relationship: _____
Telephone Number: (_____)_____ Alternate Number: (_____)_____

INSURANCE INFORMATION

Company Name: _____ Insured's Name: _____
Insured's SSN: _____-_____-_____ Birth Date: ___/____/____ Employer of Insured: _____

PRIMARY CARE PHYSICIAN

Primary Care Physician: _____ Office Location: _____
Telephone Number: (_____)_____ Date of Last Visit: _____

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Name: _____ Date: _____

Height: _____ Weight: _____ Children (list ages and sex): _____

HEALTH HISTORY

PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:
CIRCLE THE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS.

❑ AIDS	❑ Breast Lumps	❑ Epilepsy	❑ Measles	❑ Pacemaker	❑ STD
❑ Alcoholism	❑ Cancer	❑ Lymes Disease	❑ Multiple Sclerosis	❑ Pneumonia	❑ Stroke
❑ Anemia	❑ Chicken Pox	❑ Fibromyalgia	❑ Mumps	❑ Polio	❑ Tuberculosis
❑ Appendicitis	❑ Diabetes	❑ Goiter	❑ Pacemaker	❑ Rheumatic Fever	❑ Ulcers
❑ Arteriosclerosis	❑ Eczema	❑ Gout	❑ Parkinson's	❑ Rheumatoid Arthritis	❑ Other _____
❑ Asthma	❑ Emphysema	❑ Heart Disease	❑ Prostate	❑ Scarlet Fever	❑ Other _____

1. Please list any medications/supplements/vitamins you are presently taking: _____

_____

2. Please list all previous surgeries and hospitalizations (include dates): _____

_____

3. Please list all allergies: _____
4. Please list all dates of motor vehicle collisions, if any: _____
5. Please list all fractures and dislocations: _____
6. **Women Only** – Are you pregnant? ❑Yes ❑No Taking Birth Control? ❑Yes ❑No Last menstruation? ____/_____/_____

Date of Last (Approx.)

_____ Physical Exam
_____ Blood Test
_____ X-ray
_____ MRI
_____ CT Scan
_____ Urine Test

	None	Light	Moderate	Heavy
Alcohol	❑	❑	❑	❑
Caffeine	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑

1. Sleep Position:
❑ Side ❑ Stomach ❑ Back
2. Do you wear orthotics? ❑ Yes ❑ No
3. Rate your stress level _____
(0 = no stress, 10 = severe stress)

CURRENT COMPLAINTS

Please check the appropriate box for any of the following symptoms, which you now have or have had previously.
THIS IS A CONFIDENTIAL HEALTH REPORT

CARDIO-VASCULAR	RESPIRATORY	SKIN	GENITO-URINARY
❑ Hardening of the arteries	❑ Chronic cough	❑ Bruise easily	❑ Bed-wetting
❑ High blood pressure	❑ Difficultly breathing	❑ Dryness	❑ Blood in urine
❑ Low blood pressure	❑ Wheezing	❑ Skin eruptions (rash)	❑ Frequent urination
❑ Pain over heart	❑ Spitting up blood	❑ Discolorations	❑ Kidney infection
❑ Poor circulation	❑ Spitting up phlegm	❑ Varicose veins	❑ Kidney stones
❑ Rapid heartbeat			❑ Painful urination
❑ Chest pain			❑ Prostate problems
			❑ Pus in urine

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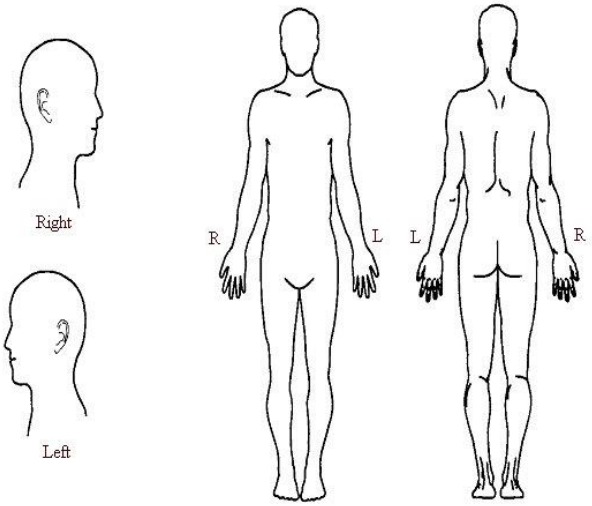
EENT	GASTRO-INTESTINAL	FOR WOMEN ONLY	NERVOUS SYSTEM
❑ Eye pain/strain ❑ Vision problems ❑ Ear pain ❑ Ear noises ❑ Ear discharge ❑ Hearing loss ❑ Nose pain ❑ Nose bleeds/discharge ❑ Nasal obstruction ❑ Sore mouth ❑ Sore throat ❑ Hoarsens ❑ Difficult speech ❑ Sinus infection ❑ Jaw pain	❑ Appetite changes ❑ Difficulty chewing/swallowing ❑ Excessive thirst ❑ Nausea ❑ Vomiting blood ❑ Abdominal pain ❑ Diarrhea ❑ Constipation ❑ Bloody/black stool ❑ Hemorrhoids ❑ Liver problems ❑ Gallbladder problems ❑ Weight trouble	❑ Back ache or cramps ❑ Excessive menstrual flow ❑ Hot flashes ❑ Irregular cycle ❑ Menopausal symptoms ❑ Painful menstruation ❑ Vaginal Discharge ❑ Vaginal Pain ❑ Breast Pain ❑ Miscarriage	❑ Numbness/tingling ❑ Loss of feeling ❑ Paralysis ❑ Dizziness ❑ Fainting ❑ Headaches ❑ Loss of memory ❑ Muscle jerking ❑ Loss of taste/smell ❑ Cold feet/hands ❑ Convulsions ❑ Confusion ❑ Depression ❑ Insomnia

MUSCULOSKELETAL		PAIN, NUMBNESS, CRAMP	
❑ Low back pain ❑ Mid back pain ❑ Neck pain ❑ Arm problems ❑ Leg problems ❑ Swollen joints ❑ Painful joints	❑ Stiff joints ❑ Sore muscles ❑ Weak muscles ❑ Muscle spasm ❑ Walking problems ❑ Sciatica ❑ Arthritis ❑ Other _____	❑ Back ❑ Neck ❑ Head ❑ Shoulders ❑ Arms ❑ Elbows	❑ Hands ❑ Hips ❑ Legs ❑ Knees ❑ Feet ❑ Other _____

PLEASE OUTLINE ON THE DIAGRAM AREAS OF DISCOMFORT USING THE SYMBOLS BELOW:

A = Aching	N = Numbness
B = Burning	R = Radiating
C= Cold	S = Stabbing
H = Hypersensitivity	T = Tingling



PRIMARY COMPLAINT

Out of all your concerns, which is the <u>most troublesome</u> to you? _____

Please indicate the level of pain and/or discomfort you are experiencing to the above condition.

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst pain imaginable**

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CONSENT TO CHIROPRACTIC SERVICES

CONSENT TO CHIROPRACTIC SERVICES INITIALS: _____

I hereby request and consent to chiropractic manipulations and other procedures including various modes of physical therapy, diagnostic x-rays, and/or tests by Delmarva Chiropractic and their staff who now, or in the future treat me while employed by this office. I have had to discuss with Dr. Lane/Dr. Brown and/or with other clinic personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of chiropractic, there are some risks to treatment including but not limited to fractures, disk injuries, strokes, dislocations, and strain/sprains. I do not expect the doctor to be able to anticipate or explain all risks and complications, and will rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me the full above consent and have also had the opportunity to ask questions about it's content, and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic and/or employed staff.

FEMALE PATIENTS INITIALS: _____

This is to certify that to the best of my knowledge I am NOT pregnant and the Delmarva Chiropractic has my permission to take x-rays, and or perform all necessary test. Beginning date of your last menstrual period _____.

PAYMENT AND INSURANCE INITIALS: _____

I understand and agree that the health and accident insurance policies are an arrangement made between the insurance carrier and myself. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to pay directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible both for payments, and knowledge of my insurance policy. Delmarva Chiropractic P.C. is not responsible for such information and will assume no responsibility for monies owed due to insurance cessation. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signed: _____ Date: _____

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PATIENT NOTIFICATION OF FINANCIAL RESPONISBILITY

I understand that I may be financially responsible for any charges incurred at this office, including co-payments, deductibles, and charges denied or not covered by my insurance company.

I realize that my care may be subject to pre-authorization by my insurance company, and I accept all responsibility for any treatments, which are determined to be not medically necessary. I understand Delmarva Chiropractic P.C. will submit all required documentation to the insurance company, or their designee, so that a review relative to determination of medical necessity can be made for subsequent treatment. I understand that both Delmarva Chiropractic P.C. and I will receive direct notification from the insurance company, or their designee, and will be advised as to whether additional treatment has been approved or denied and the number of visits that have been approved for a specified time period. Charges for services determined to be not medically necessary by the insurance company will be my responsibility.

INITIALS: _____

Insurance policy limitations are per individual insurance policy plans, as are co-payment, co-insurance, deductibles, and/or referrals.

INITIALS: _____

I understand that Delmarva Chiropractic P.C. reserves the right to charge me $25 for any appointments that are cancelled without 24 hours of notice.

INITIALS: _____

If the undersigned fails to make any payments due hereunder, Delmarva Chiropractic P.C. may at any time thereafter without notice or demand after, declare the entire unpaid balance of the account to be immediately due and payable. The undersigned promise to pay all cost of collection including but not limited to court cost, attorney fees equal to fifteen percent (15%) of any amount due and owing to Delmarva Chiropractic P.C. and all other collection costs. The undersigned expressly agrees and stipulates that if in the sole discretion of Delmarva Chiropractic P.C. its representative or its attorney's litigation or court process is necessary to enforce payment hereunder, that the venue for any such litigation or court process shall be the circuit court for Wicomico County Maryland and the undersigned expressly waives any right to of venue for any such litigation or trial in any county or jurisdiction other than Wicomico County.

INITIALS: _____

I have read and understand my obligations for payment for care at Delmarva Chiropractic.

_____ _____
Print Name Date

_____ _____
Signature (Patient, Parent or Guardian) Witness

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MEDICAL AUTHORIZATION

Patient's Name: _____

Date of Birth: _____

Social Security Number: _____

I, _____, hereby authorize the said clinic for obtaining all information relative to my physical and/or mental condition, past, present, or future from all doctors and other healthcare professionals who have treated me, and all hospitals and other healthcare institutes, in which I have ever been a patient.

_____ _____

Patient's Signature Date

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Notice of Privacy Practices

Effective **September 23, 2013**

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.

The Practice (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is also required by law to abide by the terms of this Notice.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

For Treatment – We may use your PHI to provide you with treatment. We may disclose your PHI to doctors, nurses, technicians, clinicians, medical students, hospitals and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other health care providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another health care provider, we would, as part of the referral process share PHI information about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

For Payment – We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the health care services we provided to you so your insurance company will pay us for those services or reimburse you for amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your condition and the health care you need to receive prior approval or to determine whether your plan will cover the services.

For Health Care Operations – We may use and disclose your PHI for our own health care operations and the operations of other individuals or organizations involved in providing your care. This is necessary for us to operate and to make sure that our patients receive quality health care. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

OTHER USE & DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

Appointment Reminders -We may use and disclose your PHI to remind you by telephone or mail about appointments you have with us, annual exams, or to follow up on missed or cancelled appointments.

Individuals Involved in Your Care or Payment for Your Care – We may disclose to a family member, other relative, a close friend, or any other person identified by you. Certain limited PHI that is directly related to that person's involvement with your care or payment for your care. We may use or disclose your PHI to notify those persons of your location or general condition. This

includes in the event of your death unless you have specifically instructed us otherwise. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others.

Disaster Relief - We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend or other individual of your location and general condition.

De-identified Information – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

Business Associate – The Practice may use and disclose PHI to one or more of its business associates 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.

Personal Representative – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

Emergency Situations – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Public Health and Safety Activities – The Practice may disclose your PHI about you for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury or disability
- To report births or deaths
- To report child, elder, or dependent adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence – We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is (a) required by law, (b) agreed to by you, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or, (d) if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

Health Oversight Activities – We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation's health care system, government benefit programs, and for the enforcement of civil rights laws.

Judicial and Administrative Proceedings – We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes – We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury or administrative order, warrant or subpoena
- To identify or locate a suspect, fugitive, material witness or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
- To alert a potential victim or victims or intending harm ("duty to warn")
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime or a person who committed a crime in emergency circumstances

To Avert Serious Threat to Health or Safety – We will use and disclose your PHI when we have a "duty to report" under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

Coroners, Medical Examiners and Funeral Directors – We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

Organ, Eye or Tissue Donation – To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.

Workers Compensation – We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Special Government Functions – If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Research – We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that information that identifies who you are, we will ask for your permission.

Fundraising – We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:

Marketing Purposes – We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

Sale of Health Information – We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

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YOUR RIGHTS

Right to Revoke Authorization – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Right to Request Restrictions – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket and we will abide by that request unless we are legally obligated to do so.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

Right to Receive Confidential Communications – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work.

If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

Right to Inspect and Copy – You have the right to inspect and request copies of your information.

To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If you request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy

Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: **Michelle Atkins**

Address: **1324 Belmont Ave 201 Salisbury, Maryland 21804**

Telephone No.: **410-219-5155**

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: _____ Date: _____

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)

Native/ Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

Family Health History (Circle One) Father/Mother/Brother/Sister/Daughter/Son

Condition _____

Patient Signature: _____ Date: _____

For office use only

Height:____ Weight:____ Blood Pressure: L_____ /_____ R_____/_____ Resp.____ Ox_____ Pulse _____Temp_____

EHR □ Pt Info □ Demo □ SCAN □

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Thank you for choosing Delmarva Chiropractic, where we want to help you achieve your path to better health. In doing so, we would like to inform you of the following.

NON-COVERED SERVICES

Thank you for choosing Delmarva Chiropractic P.C., where we want to help you achieve your path to better health. In doing so, we would like to inform you of the following:

The services and/or products listed below may be recommended by your provider, but are **NOT** covered by your medical insurance.

I acknowledge that I will be financially responsible for the treatment/testing below recommended by my provider for patient care.

- **Maintenance Care** - $60.00 per visit (Chiropractic Maintenance Care is treatment received in order to prevent future pain or health problems to prevent a relapse and to improve quality of life. Maintenance Care is elective).
- **Laser Treatment** - $25.00 (Physiological and Biological written effects of laser therapy will be provided.)
- **NSI** - $25.00 initial visit, $5.00 per treatment (Neuro Sensory Integration is the testing for brain sensory dysfunction and is a stand -alone modality for Neurology patients.)
- **Rock/Kinesio Taping** - $10.00 (Used for musculoskeletal, sports injuries and inflammatory conditions.
- **Decompression- $**60.00 each individual treatment or group of 10 treatments $500.00 (due at onset).

INITIALS: _____

The products listed below may be recommended by your provider for purchase to aid you with your at home care/therapy.
I acknowledge that I will be financially responsible for the purchase of the items below.

- **Tubing** - $5.00
- **Band** - $5.00
- **Foam Roller** - $15.00

INITIALS: _____

All of our patients that receive electrical muscle stimulation as a part of their therapy will be charged an individual fee for stim pads. Every individual will have their own personal set which are kept in the office and will last approximately 10-15 visits.
I acknowledge that I will be financially responsible for the purchase of the item listed below.

- **Electrical Stim Pads** - $10.00

INITIALS: _____

Individuals may be offered orthotics. If your health insurance plans do not cover this product or if the carrier allowance is far below the amount of the cost such that a balance remains, then you are financially responsible for all non-covered items ordered on your behalf.

I acknowledge that I have been advised of this information and that I agree to pay this office for any amount that is not covered by insurance.

INITIALS: _____

Patient Name: _____ Date: _____