SPENCER CHIROPRACTIC
STEVEN W. SPENCER, D.C.
9000 ROGERS AVENUE, SUITE C
FORT SMITH, AR 72903
PHONE: (479) 434-4120

PATIENT INFORMATION

PLEASE PRINT DATE__________

NAME__________ PHONE__________

MAILING ADDRESS__________ CITY__________

STATE______ ZIP______ SOCIAL SECURITY # __________

EMAIL ADDRESS: __________

DATE OF BIRTH______ AGE______ SEX______ MARITAL STATUS M S W D

HEIGHT______ WEIGHT______ EMPLOYER __________

OCCUPATION__________ ADDRESS__________

WORK PHONE__________ NAME OF SPOUSE__________

SPOUSE EMPLOYER__________ OCCUPATION__________

ADDRESS__________ PHONE NUMBER__________

NAME OF PARENTS OR GUARDIAN IF UNDER 18 __________

WHO REFERRED YOU TO THIS CLINIC? __________

DESCRIBE YOUR PRESENT PROBLEM: CIRCLE WHETHER YOU ARE HAVING PAIN, NUMBNESS OR BOTH.

1. WHERE DO YOU HAVE THE PAIN, NUMBNESS OR BOTH? __________
2. HOW LONG HAVE YOU HAD THE PAIN, NUMBNESS OR BOTH? __________
3. WHEN DOES THE PAIN, NUMBNESS OR BOTH OCCUR? __________
4. DO YOU KNOW WHAT HAS CAUSED THE PAIN? __________

PLEASE CIRCLE: IS PAIN RELATED TO WORK ACCIDENT? Y N AUTO ACCIDENT? Y N

OTHER DOCTORS SEEN FOR THIS CONDITION? __________

WERE X-RAYS TAKEN? Y N WHERE? __________

HAVE YOU BEEN TREATED FOR ANY HEALTH CONCERN BY A PHYSICIAN IN THE PAST YEAR? Y N

IF YES, DESCRIBE__________

QUESTIONS CONTINUED ON REVERSE SIDE OF FORM

WHAT MEDICATIONS ARE YOU NOW TAKING? ___________________________

____

DATE OF LAST PHYSICAL EXAM ___________________________

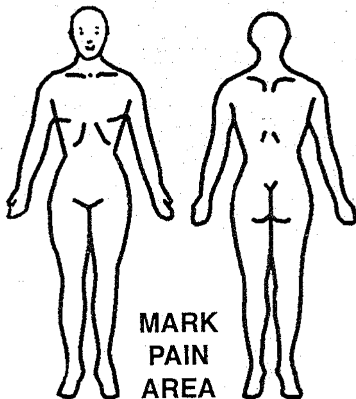
LIST SURGERIES/IMPLANTS YOU HAVE HAD ___________________________

HAVE YOU BEEN TREATED BY A CHIROPRACTOR BEFORE? Y N WHEN? ___________

CHIROPRACTORS NAME ___________________ WHERE? ___________________

PLEASE CIRCLE SYMPTOMS YOU HAVE NOW OR HAVE HAD PREVIOUSLY

NERVOUSNESS - DEPRESSION
NECK PAIN/STIFFNESS
PAIN BETWEEN SHOULDERS
PAIN OR NUMBNESS IN:



HEADACHES
FEVER
LOSS OF SLEEP
WEIGHT LOSS
ARTHRITIS
HERNIA
NOSEBLEEDS
SINUS INFECTION
SORE THROAT
STOMACH PAIN
GALL BLADDER
CONSTIPATION
CHRONIC COUGH
POOR POSTURE
BLOOD IN URINE
INABILITY TO CONTROL KIDNEYS
HIGH BLOOD PRESSURE

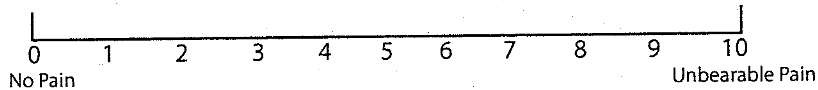
VARICOSE VEINS
CRAMPS
ALCOHOLISM
CANCER
DIABETES
EPILEPSY
EMPHYSEMA
DIZZINESS
FAINTING
FATIGUE
POOR CIRCULATION
PAINFUL URINATION
ANKLE SWELLING
DIFFICULT DIGESTION
HARDENING OF ARTERIES
KIDNEY INFECTION
LOW BLOOD PRESSURE

SWOLLEN JOINTS
HEART DISEASE
STROKE
ULCERS
HOT FLASHES
HAY FEVER
EARACHE
LIVER TROUBLE
COLON TROUBLE
BACKACHE
CHEST PAIN
KIDNEY STONES
NUMBNESS

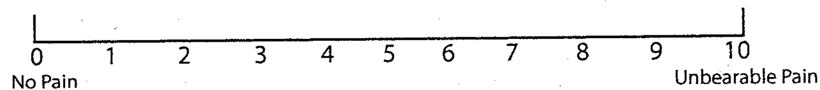
FOR WOMEN ONLY: ARE YOU PREGNANT? YES NO

How do you feel today?

Current complaint:



Average pain level over the past week:



Patient's Signature X ___________________________ Date ___________

AUTHORIZATION AND ASSIGNMENT

TO: Steven W. Spencer, D.C.

In consideration of you undertaking to treat me, I agree to the following:

Authorization to Release Information: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequences thereof.

Assignment of Cause of Action: In the event any insurance is obligated by contractual agreement to make payable to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is/are said to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit. However it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance proceeds, I personally owe you and agree to pay in a current manner.

Authorization to Pay Directly to the Doctor: Spencer Chiropractic. In consideration of the chiropractic services rendered and to be rendered by him, I authorize and direct the payment to the doctor named above of any sum I or hereafter owe him by you, my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges of his services or otherwise obligated to make payment to me or him based in whole or in part upon the charges for his services.

Acknowledgment and Understanding: I hereby acknowledge that I am receiving or about the receive health care services at Spencer Chiropractic Clinic, and I have been advised that the doctor providing the services is-are willing to wait for payment for these services provided that there continues to be reasonable chance that if it is determined either:

(A) That there is no insurance company obligated to pay for these services, or if the insurance company involved refuses to acknowledge an assignment to the doctor or make other provisions for the protection of the interest of the doctor or

(B) If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor or if I have not engages the services of an attorney, then payment for services rendered by the doctor at Spencer Chiropractic Clinic will be made on a current basis and my bill will be paid in full as soon as my liability claim is settled or the passage of three months from my last treatment whichever occurs first.

Should this account be referred to an attorney or third party for collection, the undersigned shall agree to pay reasonable fees and collection costs.

Dated the______day of__________________, 20____

______________________________ ______________________________

Patient Signature Witness Signature

Notice of Privacy Practices

Spencer Chiropractic Clinic
9000 Rogers Ave., Ste. C
Fort Smith, AR 72903

Effective Date: April 14, 2003

A federal regulation, known as HIPPA Privacy Rule, requires that we provide detailed notice in writing of our privacy practices. In this notice, we describe the ways that we may use and disclose health information about our patients. This Rule requires that we protect the privacy of health information that identifies a patient such as your date of birth, address, health information, and religious affiliation, if any, and information about your health plan. This information is called Protected Health Information or PHI.

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share the medical information. We reserve the right to change our privacy practices and the terms of this notice and to make the new notice effective for all PHI. If and when this notice is changed, we will post a copy in our office and provide you receive a revised copy upon request.

The following list describes the different ways we may use and disclose medical information for treatment, payment or health care operations without your consent or authorization and some examples of how they may occur.

TREATMENT: We may use and disclose PHI so that we can provide, coordinate or manage your health care and related services. We may consult with other health care providers regarding your treatment. In emergencies, we may use and disclose your information to provide the treatment you need.

PAYMENT: We may use and disclose PHI so that we can bill and collect payment for the treatment that was provided to you. We may share details with your health plan concerning the service you are scheduled to receive and confirm you are receiving the appropriate amount of care to obtain payment. We may use and disclose PHI for billing, claims management insurance companies providing you with additional coverage and collection activities or reporting agencies relation to collection of payments owed to us.

HEALTH CARE OPERATIONS: We may use and disclose PHI in performing business activities that allow administration to review and improve the quality care we provide and to reduce health care costs efficiency. Also, we can disclose information to cooperate with outside organizations that audit, evaluate, certify, or license health care providers. PHI and services provided to you may be seen and reviewed by accountants, lawyers, other doctors, or anyone who may assist us with our business or management of our business.

DISCLOSURES TO YOU: We may contact you to remind you of appointments and to provide you with the information about treatment alternatives. We may communicate with you regarding your insurance plan, claims, co-payments, outstanding balances or other aspects connected to your medical care.

DISCLOSURES WITH FAMILY & FRIENDS: We may disclose PHI about you to your family member, close friends or any other person identified by you if that information is directly relevant to the person's involvement in our care or payment for your care. Before we disclose your PHI to a person involved, we will provide you with an opportunity to object. If you are not present, or if you are incapacitated, we may share limited information based on our professional judgment of whether the disclosure would be in your best interest. We may notify such persons of your location, condition or death. We may also use professional judgement to make decisions in allowing a person to pick up medical supplies, x-rays or other things that concern you.

We are required by law to use and disclose your PHI without your written consent under special circumstances which include:

- Secretary of DHS for investigating a complaint.
- Public health activities, such as preventing or control disease, injury or disability.
- Government oversight agency conducting audits, investigations, civil or criminal proceedings.
- Law enforcement officials to report a suspected crime victim or of a death that we suspect was the result of a criminal conduct.
- Court or administrative subpoena, summons or discovery request.
- To identify or locate a suspect fugitive material witness or missing person.
- To report disease, injury, child abuse or neglect.
- We will make reasonable efforts to avoid incidental of your PHI. An example is conversations overheard between the doctor, medical staff and patient. We have reasonable safeguard against such incidental uses and disclosures.

You have the right to request an accounting of certain disclosures that we have made of PHI up to six years after April 14, 2003. All requests must be in writing. We may deny your request in certain cases.

If you have any questions concerning this privacy practice, you may contact the office manager. If you believe that your privacy rights have been violated, you may file a complaint with the Secretary of United States Dept. of Health and Human Services within 180 days of when you believe a violation occurred. You may also file a complaint with us at the address on this form. All complaints must be in writing.

I have read, understand, and received a copy of the notice of privacy practices for Spencer Chiropractic Clinic.

______________________________   __________________

Signature   Date