

NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name: _____ Today's Date: _____

Address: _____

City/State/Zip: _____ E-Mail: _____

Phone: Home _____ Work: _____ Fax: _____

Cell #: _____ Pager: _____ Marital status: _____

Birth date: ____/____/____ Age: _____ Social Security #: _____

Who may we thank for referring you? _____

Have you ever seen a chiropractor before: _____ Name of Dr. _____

Chiropractic techniques you've had success with: _____

Last time you went to previous Doctor of Chiropractic: _____

General Practitioner: _____ and City _____

Your employer: _____ Phone number: _____

Occupation: _____

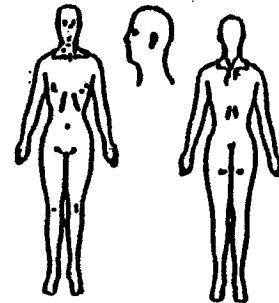
Spouse's name: _____

Spouse's employer: _____

Children's names & ages: _____

Favorite hobbies or interests: _____

Mark area(s) of Health Concerns:



Evaluation is complementary, any fees will be discussed before they occur. Method of payment for first visit:
____ Cash ____ Check ____ Credit Card

Do you have health insurance? ____ Name of company: _____

Who is the policy holder: _____

Policy holder Birthday: _____ SS#: _____



Health reasons for consulting our office:

1. _____ 3. _____
2. _____ 4. _____

Have you had same or similar problem(s) before? ___Yes ___No

How long?:

Please explain:

Father/Mother/Brother/Sister/Children, with similar problems?

Other doctors who have treated this problem: _____

Surgery you have had: _____

Medication(s) you currently take: _____

Is there any chance you are pregnant? Yes ___ No ___

What have you heard about chiropractic care?

Do you know what a subluxation is? If yes, please describe

What daily rituals for spinal health do you presently practice?

PRACTICE MEMBER ACKNOWLEDGEMENTS

It is understood and agreed that the amount paid to McLaughlin Chiropractic for X-Ray studies, is for the examination only and the X-Ray negatives will remain the property of the clinic, being on file where they may be seen at anytime by a practice member of this clinic.

Signature: _____ Date: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. However, I clearly understand that I am personally responsible for payment of any services not covered by my insurance. I also understand that any fees for professional services rendered to me will be immediately due and payable. I give permission for the insurance to pay the doctor directly.

Signature: _____ Date: _____

My care at McLaughlin Chiropractic is NOT due to an automobile accident, work related injury, or any other type of accident.

Signature: _____ Date: _____

The above information is true and accurate to the best of my knowledge. My reason for consultation with the doctor is for evaluation of my physical health and the potential improvement.

Signature: _____ Date: _____

SHORT FORM
Privacy Consent Form / Required by Federal HIPAA Law #101-191
For Use or Disclosure of Private Health Information

- Trust is the foundation of a doctor/patient relationship
- The information that you provide us is kept in the strictest of confidence
- While protecting your privacy is extremely important to us, there may be certain situations in which we may have to use or disclose your health care information:
 1. It may be necessary to use or disclose your private health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health information.
 2. It may be necessary to use or disclose your private health information and billing records to another party if they are responsible for the payment of your services
 3. It may be necessary to use or disclose your private health information within our practice for quality control and operational purposes.

Please note:

We have a more detailed "Notice of Privacy for Private Health Information" and you have the right to review the detailed notice before you sign this consent form. We have the right to change our privacy practices as described in the detailed notice. If any changes occur in reference to our privacy practices, you will be notified by a posting of the change in the office or a notice will be sent to you in the mail. You may request a copy of our privacy notices at any time.

Patient Rights Under HIPAA LAW #101-191

1. You have the right to request that we do not disclose your private health information to specific Individuals, companies or organizations under the following circumstances:
 - a. All requests must be in writing
 - b. By law we are not required to agree with your restrictions, **HOWEVER**,
 - c. If we agree with your restrictions, the restriction is binding on us.
2. You have the right to **REVOKE** your authorization under certain conditions:
 - a. It must be in writing.
 - b. The request will not be honored if we have already released your private health information before we received your request to revoke the authorization.
 - c. If you were required to give your authorization as a condition of obtaining insurance, the insurance may have the right to your private health information should they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I also acknowledge that once I sign this consent form, I will receive a copy of this completed form for my own records.

Printed Patient Name

Mary Alice McLaughlin, D.C.

Printed Authorized Provider Name

Signature

Mary Alice McLaughlin D.C.

Signature

Signature

Date

Signature

Date

Authorization for Appointment Reminders and Health Care Information

There may be times when the doctor or members of the doctors team may need to use your private health information such as your name, address, phone number in order to contact you in regards to appointment reminders, requested information about alternative treatment or other health related information. If you are not at home to receive this information we would like to leave you a message. By signing this form you are giving us authorization to contact you and/or leave you a message.

Signature: _____

Date: _____

Authorization For Appointment Reminders, Marketing and HealthCare Information

There may be times when the doctor or members of the doctors team, may need to use your private health information such as your name, address, phone number or clinical records in order to contact you in regards to:

- Appointment reminders
- Information about alternative treatment
- Or other health related information that may be of interest to you
- Mailing out of our newsletter, cards and promotional mailings
- Picture photo on our bulletin board, patient testimonials and other printed material

If you are not at home to receive an appointment reminder, a message could be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and/or information.

Your Rights

You may restrict the individuals or organizations to which your PHI is released
Or you may revoke your authorization to us at any time with the following rules:

Your revocations must be in writing and mailed to us at our office address

We will not be able to honor your revocation request if:

If we have already released your private health information before we received your request to revoke the authorization.

If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your private health information should they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone that has access to the reminder or other information and may no longer be protected by the federal privacy rules.

If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for services rendered to you.

You have the right to inspect or copy the information that we use to contact you for appointment reminders, marketing or other health related information at any time.

This notice is effective as of _____.

This notice will expire seven (7) years after the date upon which the record was created.

I have read your authorization and agree to its terms.

My signature authorizes you to disclose my private health information in the manner described above and acknowledges that I will receive a copy of this completed form for my own records.

Printed Patient Name

Patient Signature

Date

Mary Alice MC Laughlin D.C

Printed Authorized Provider Name

Mary Alice MC Laughlin D.C
Signature of Authorized Provider Name

Date

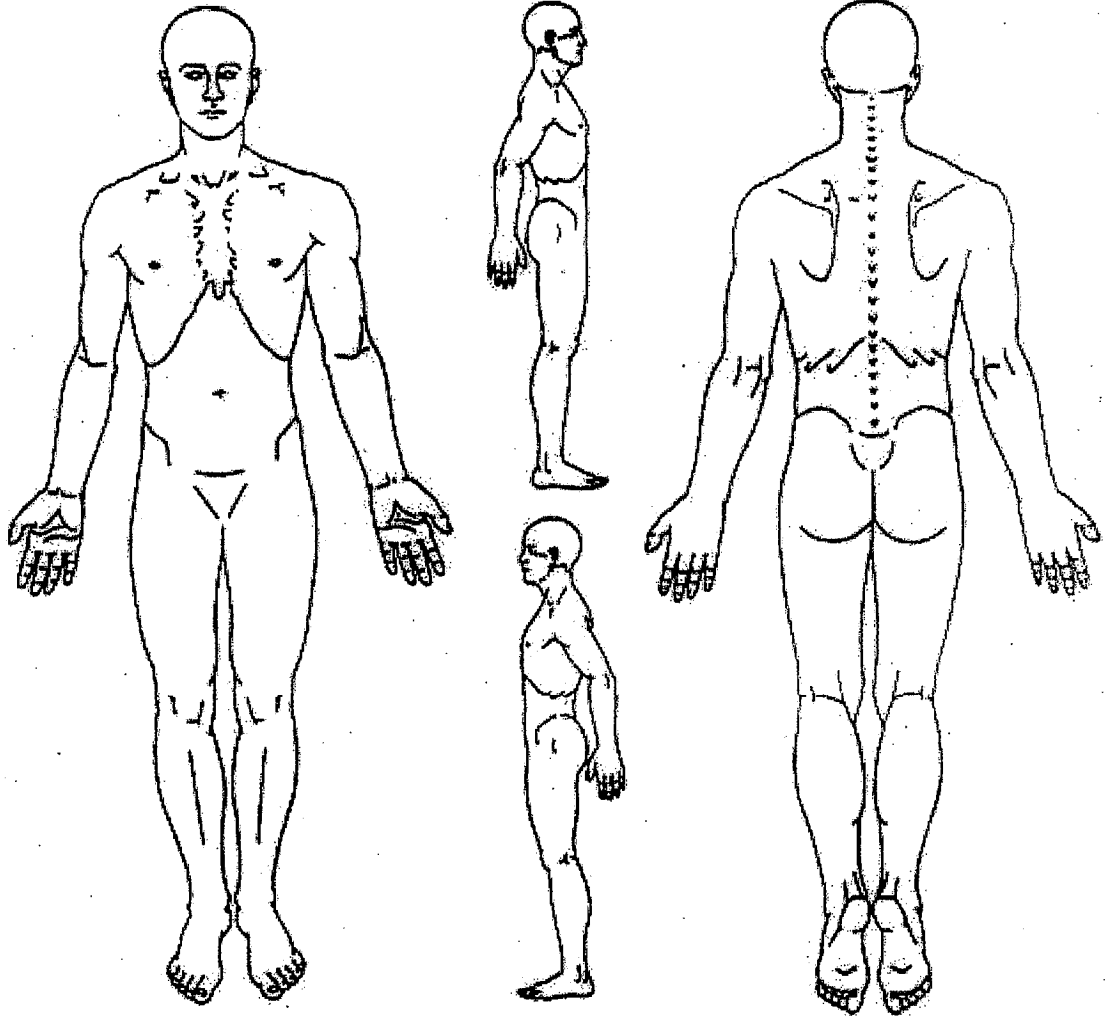
Pain Assessment

NAME-

DATE-

EXTREME PAIN

- 10
- 9
- 8
- 7
- 6
- 5
- 4
- 3
- 2
- 1



Please indicate the areas of your pain in the above figures using the number level of pain.