WILLIAMS
CHIROPRACTIC & DECOMPRESSION CENTER P.C.

DATE:_____/_____/_____

ABOUT YOU:

First Name:_____ Middle Initial:_____ Last Name:_____
Preferred to be called:_____
Date of birth: _____/_____/_____
Address line 1:_____
Address line 2:_____
City:_____ State:_____ Zip Code:_____
Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____
Email Address:_____
Sex: □Male □Female Social Security #:_____
□ Married □ Single □ Separated □ Divorced □ Widowed □ Minor

Spouse Data

Is your spouse a patient in the clinic? ☐ Yes ☐ No
First name:_____ Middle Initial:_____ Last Name:_____
Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Employer: _____
Spouse D.O.B:_____/_____/_____

Employer Data

Name:_____ Position: _____
Address line 1:_____
Address line 2:_____
City:_____ St.___ Zip Code:_____

Insured's Data:

Insurance Company Name _____ Group Number _____
Name of Insured (Policy Holder) _____ Policy Number _____
Insured Birthdate _____ Relationship to Insured _____
Insured SS#: _____ Insured Employer_____

Emergency Contact

Contact Name: _____ Relationship: _____

Contact Phone: (_____)_____-_____

May We Call You At Work? □ Yes □ No

Primary Care Physician's Name & Clinic _____

How did you hear about our office?

□ Family Member □Attorney □Website □Health Class □Friend □Brochure

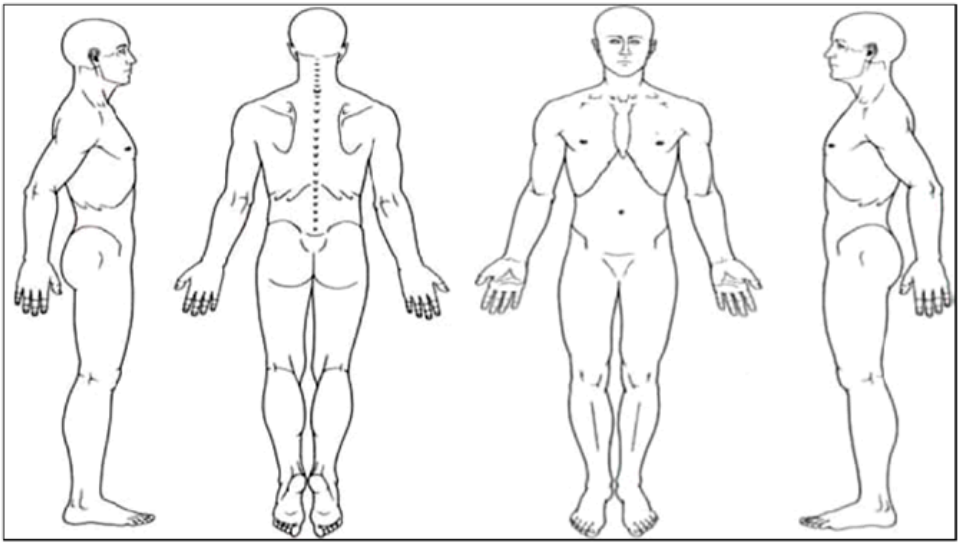
□Physician □Newspaper □Internet □Employer □Other _____

If you listed Friend, Employer or Physician please list their name so we can thank them_____

Reason for Today's Visit:

□New Injury □Old Injury □Chronic Pain □Wellness

By using the key below, indicate on the body diagram where you are experiencing the following symptoms: # = Numbness X = Burning % = Stabbing 0= Pins & needles +=Ache



Describe your symptoms:

_____

_____

_____

_____

□Sharp □Ache □Dull

□Tingling □Burning □Numb

□Stabbing □Shooting

When did symptoms begin: _____ Is pain affecting your social life? _____

Cause of Pain: (check all that apply)

□Traumatic □Chronic □Post-surgical □Motor vehicle accident □Work related

□Unknown □Sudden Onset □Gradual Onset □Other _____

How often do you experience your symptoms?

□Constantly (70-100% of day) □Frequently (51-75% of day) □Occasionally (26-50% of day) □Intermittently (0-25% of day)

Rate your pain on a scale of 0-10 (0=none; 10=worst) _____

List any other healthcare professionals you have seen for your symptoms & treatments given:

_____

_____

What tests have you previously had performed for your symptoms, and list the date received:

□X-Rays □MRI □CT Scan □Other_____

List any medications/herbs/supplements you are currently taking along with dosage:

_____

_____

_____

_____

Check any other symptoms you have or have previously had:

□Arthritis / Gout	□ Depression/Anxiety	□ Pregnancy	□ High Cholesterol	□ Headaches
□ Eye Pain–Strain	□ Dizziness	□ Seizures	□ Ringing in Ears	□ Blurred Vision
□ Jaw Pain	□ Hepatitis C	□ Neck Pain / Spasms	□ Chronic Fatigue	□ Heart Disease
□ Gall Stones	□ Swallowing Difficult	□Thyroid Problems	□ Chest Pain - SOB	□ Cancer
□ Anemia / Bleeding	□ Hypertension	□ Stroke / CVA / TIA	□ Kidney Problems	□ Pancreatitis
□ Shortness of Breath	□ Irregular Heart Beat	□ HIV / AIDS	□Asthma/Bronchitis	□ Mid/Low Back Pain
□ Shoulder/Elbow Pain	□ Wrist or Hand Pain	□ Neuropathy	□ Hip/Knee/Leg Pain	□ Foot or Ankle Pain
□ Stomach / Ulcer Pain	□ Diabetes	□ Groin or Rectal Pain	□ Female Disorders	□ Urinary Problems
□ Skin Problems	□ Broken Bones	□ Digestive Problems	□ Emphysema / COPD	□ Irregular Bowels

□ Other problem(s) not listed _____

Please list all Surgeries with dates and/or any serious health conditions not listed above:

_____

_____

Allergies: □None

□Eggs □Soy □Fish/Shellfish □Gluten □Milk/Lactose □Peanuts

□Sulfites □Other _____ □Allergies to medications _____

Social History:

□Occasional caffeine use □Often caffeine use

□Drink Alcohol □Yes □No Approximately how many drinks per week _____

□Smoke/Use tobacco □Yes □No How many packs per day _____ For How many years_____

□Do not exercise □Exercise occasionally □Exercise often □Experience stress occasionally

□Experience stress often □Wear seatbelts occasionally □Wear seatbelt often □Never wear seatbelt

Family History: If check any boxes below, please include relationship to family member

□Arthritis _____ □Cancer _____ □Cholesterol _____

□Heart Problems _____ □High Blood Pressure _____ □Psychiatric _____

□Diabetes _____□Thyroid _____ □Stroke _____

□Other _____

Children

List Number of children & Ages: _____

Substance Use

□Amphetamines (past)	□Amphetamines (present)	□Barbituates (past)	□Barbituates (present)
□Crystal meth (past)	□Crystal meth (present)	□Heroin (past)	□Heroin (present)
□Cocaine (past)	□Cocaine (present)	□Marijuana (past)	□Marijuana (present)

Insurance Information

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give this power of attorney to endorse checks made out to me to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to my 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.

_____ Patient/Guardian Initial

Release of Information

In the event that Dr. Williams, Dr. Evans, or Dr. Raines believes it is necessary for a second opinion or finds it necessary to contact my primary or treating physician, I authorize this office to release my medical records arising from said treatment.

_____ Patient/Guardian Initial

Assignment of Proceeds

I hereby direct all payers to release ANY information regarding any coverage or benefits to pay directly to Williams Chiropractic and Decompression Center, P.C. I authorize this office to release any information to insurance carries regarding my treatment to facilitate collection. I agree that all provisions to this agreement are reasonably necessary for the protection of the rights and interests of Williams Chiropractic and Decompression Center PC and myself.

_____ Patient/Guardian Initial

By my signature below and the initials above, I acknowledge I have read, understand and agree to the above provisions:

Patient Signature: _____ Date:_____

Signature of Parent or Guardian: _____Date: _____

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below for whom I legally responsible):
_____ by the chiropractic and/ or anyone working in this office authorized by the chiropractic physician.
I further understand that such chiropractic services may be performed by the physician of chiropractic named here: Williams Chiropractic & Decompression Center, P.C., Williams Chiropractic Clinic, P.C., or Pain and laser Centers of N.C., PLLC and/or other licensed physicians of chiropractic whom may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Aaron M. Williams, D.C.; Dr. Linzie Evans, D.C., and DR. Sara Rains /or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.
I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries and strokes (CVA), dislocations, and sprains. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests, at the time, based upon the facts known.
I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility for an indefinite period.

To be completed by the patient:

Print Patients Name: _____

Signature of Patient:_____

To be completed by the patient's representative, if necessary
(E.g. if the patient is a minor or is physically or mentally handicapped.)

Print Patient's Name: _____
Signature of Representative:_____

Official Cancellation Policy!

PLEASE BE AWARE, IF AN APPOINTMENT IS NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE YOU WILL BE CHARGED A FEE OF $25.00

THIS FEE IS NOT COVERED BY YOUR INSURANCE COMPANY, AND YOU ARE RESPONSIBLE FOR IT, AND WILL BE EXPECTED TO PAY IT BEFORE RECEIVING ANY FURTHER SERVICES FROM OUR OFFICE.

THANK YOU FOR YOUR COOPERATION!

Signature: _____ Date: _____

Williams Chiropractic & Decompression Center, P.C.
NOTICE OF PRIVACY PRACTICES

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.

YOUR RIGHTS

Get an electronic or paper copy of your medical record
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
You can ask us to correct health information about you that you think is incorrect of incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree with your request, and we may say "no" if it would affect your care.

ONLY if you pay for a service or health care item out of pocket, in full, at the time of service can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer (i.e. – comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared your health information for sex years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights were violated
You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy.hipaa.complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Contact you for fundraising ideas

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *NEVER* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways:

- **Treat you**
  We can use your health information and share it with other professionals who are treating you**.** ***Example: A doctor is treating you for an injury asks another doctor about your overall health condition.***
- **Run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you when necessary. ***Example: We use health information about you to manage your treatment and services.***
- **Bill for your services**
  We can use and share your health information to bill and get payment from health plans or other entities. ***Example: We give information about you to your health insurance plan so it will pay for your services.***

How else we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues
We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and reducing a serious threat to anyone's health or safety.

Do research
We can use of share your information for health research

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when and individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use of share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative orders, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know if writing if you change your mind. For more information, please visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticeapp.html

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

EFFECTIVE September 23, 2013

Patient Print Name: _____
Patient Signature: _____
Authorized Provider Representative: _____