INFORMATION/APPLICATION FOR CARE

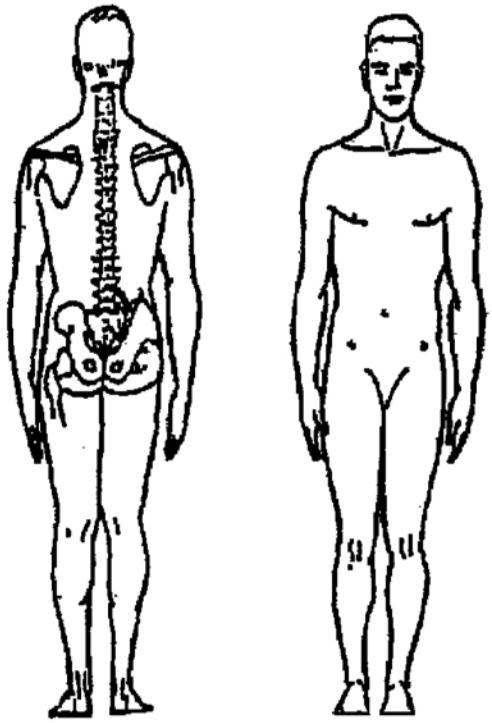
The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. (PLEASE PRINT.)

Today's Date _____

Name _____ Home Phone _____ Work Phone _____
Cell Phone _____ E-Mail Address _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth date _____ Marital Status: S M W D Number of Children _____

Your Employer _____ Occupation _____ Years On Job ____

Do you have Medicare? Yes ____ No ____ Do you have Medicaid? Yes ____ No ____



COMPLETE THESE DIAGRAMS
Please mark the exact location of your pain on the diagram.

MAJOR COMPLAINTS
(Please list any condition you are being treated for or are experiencing.)

___ Pain ___ Numbness ___ Tingling ___ Aches

Is your pain:
___ Sharp ___ Dull ___ Throbbing ___ Constant ___ Intermittent

Are your symptoms: ___ Sitting ___ Standing ___ Walking

Affected by: ___ Bending ___ Lying down ___ Weather

Do you feel: ___Cramps ___ Burning ___ Swelling ___ Stiffness

Do your symptoms interfere with:

___ Work ___ Sleep ___Day to day activities ___ Play ___Other

On a scale of 1 – 10 (1 least, 10 most) please rate:
The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

Is your condition due to an accident? Yes _____ No _____ Date of accident? _____
Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____
Have you ever been in an auto accident? Past Year ____ Past 5 Years ____ Over 5 Years ____ Never ____

Referred to our office by: _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____
Or Guardian Signature _____ Date _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Health history

Do you have, or have you had, any of the following (*please check all the apply)*

- pneumonia
- mumps
- influenza
- rheumatic fever
- small pox
- pleurisy
- polio
- chickenpox
- thyroid disease
- diabetes
- Epilepsy
- cancer
- depression
- whooping cough
- anemia
- eczema
- measles
- arthritis
- heart disease
- rashes

If you have ever been diagnosed with another disease or condition, please describe

_____

Do you use

- coffee
- tea
- artificial sweeteners
- sugar
- alcohol
- cigarettes
- recreational drugs

Have you ever suffered from (*please check all the apply)*

- neck pain
- low back pain
- headache
- migraines
- arm back/tingling
- shoulder pain
- hand pain/tingling
- leg pain/tingling
- jaw pain
- chest pain
- lung problems
- heart problems
- abnormal blood pressure
- irregular heartbeat
- ankle swelling
- cold extremities
- blurred vision
- vision problems
- difficulty breathing
- stuffy nose
- allergies
- fainting
- weight loss
- poor appetite
- excessive appetite
- nervousness
- confusion
- depression
- dental problems
- excessive thirst
- frequent thirst
- vomiting
- prostate problem
- breast pain/lump
- cramps
- painful urination
- bladder trouble
- excessive urination
- discolored urine
- gas/bloating after meals
- heartburn
- colitis
- irritable bowel
- black or bloody stools
- constipation
- hemorrhoids
- liver problems
- stroke
- paralysis
- tingling
- numbness
- fatigue
- dizziness
- loss of sleep
- difficulty hearing
- ear pain

Past injuries can affect present health (*check all the apply)*

- falls/accidents
- head injuries
- fights
- sports injuries
- broken bones
- dislocations
- spinal tap
- surgery
- traction
- extensive dental work
- use(d) a cane or walker
- dental appliances
- knocked unconscious

If yes please describe_____

Back to Health Chiropractic

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or her preceptor and/or other licensed doctors of chiropractic who now of in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office of clinic.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignment and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use her hands or a mechanical device upon my body to adjust a joint, which may cause an audible “pop” or “click.” It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor’s interpretation thereof, as well as the doctor’s judgment and expertise in working with like cases.

I understand that as part of my healthcare, the Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which by which a third-party payer can verify that services billed were actually provided.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implantation will mail a copy of any revised notice to the address I’ve provided or forward a copy in via e-mail at my request. I understand that I

have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already take action in reliance thereon.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course or treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Name (Printed) Date Signed

_____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

_____

Witness to Patient's Signature

OFFICE FINANCIAL POLICY

1. All patients are required to pay at the time of service.

2. Our office may make payment plan arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.

3. We are no longer contracted with any insurance companies, and therefore will not be billing insurance for services provided. We are controlling costs by lowering prices and hopefully making things simpler.

4. We are not a mediator between you and your insurance company and will not enter into any dispute, as your contract is between you and your insurance company.

5. If you are referred to another specialist or discontinue care for any reason other than discharge by Dr Heather Jordahl, your entire balance is due and to be paid immediately.

6. **You understand that if you miss a scheduled appointment without giving a minimum 2 you hour notice, a fee of$35 will be billed directly to you.**

7. If you have any questions concerning this or any other matter, please speak with the receptionist prior to seeing the Doctor.

I have read and understand the Financial Policy and agree to abide by these terms.

_____ _____

Patient Signature Date

Patient Authorization for Appointment Reminders and Scheduling Matters

It is our desire for our staff to use your name, address, and/or telephone number for the purpose of contacting you to remind you about your scheduled appointments, re-evaluations, or other related issues.

The use of this information is intended to make your experience without office more efficient and productive. If you choose not to authorize this information use, your decision will have no adverse effect on your care from Back To Health Chiropractic.

Your signature indicates your authorization of this activity.

_____ _____ _____

Name (Printed) Signature Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your decision to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Back To Health Chiropractic

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release and 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.

2. I authorize the direct payment to you of any sum I now or hereafter own you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me of you based in whole of in part upon the charges made for your services.

3. In the event and insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against and such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company of companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies' proceeds, whether it is all or part of what is due. I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in the State of IA.

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization of Assignment will be in continual effort until revoked by both parties.

_____ _____

Date Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT****

I, _____, have received a copy of Back To Health Chiropractic Notice of Privacy Practices.

_____ _____ _____

Please Print Name **Signature** **Date**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices.

____ Individual refused to sign.
____ Communication barriers prohibited obtaining the acknowledgement.
____ An emergency situation prevented us form obtaining acknowledgement.
____ Other (please specify)

Back to Health Chiropractic
120 South 6th Ave
Eldridge, IA 52748

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 28, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $20.00 per hour (with a minimum of $20.00) for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {**You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us. Contact Officer: Dr. Heather Jordahl. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Heather Jordahl Telephone: 563-285-1414 backtohealth@ymail.com