Welcome

Name/Nombre: _____
Last Name/Apellido First Name/Primer Nombre

Address/Direccion: _____Apt.#:_____

City/Ciudad:_____State/Estado:_____Zip Code:_____

Home Phone: _____
Cell Phone (number and carrier):_____Email:_____

DOB/Fecha de Nacimiento:____/_____/_____ ( ) Single ( ) Married ( ) Divorce ( ) Widowed

SS#:_____ ( ) Female ( ) Male
Whom May We Notify In Case of Emergency? _____
Relationship:_____Tel. Number:_____

INJURY/LESIONES

Please describe where you are having pain/favor de indicar donde siente dolor:

_____

_____

Have you lost days of work? ( ) Yes ( ) No if so, when:

_____

List any other Doctors seen for this matter:

_____

Please list medication(s) presently taking:

_____

Are you pregnant? ( ) Yes ( ) No, How far along?

_____

Do you have any metal/plastic/implants/pacemaker in your body? ( ) Yes ( ) No, if so where?

_____

HEALTH HISTORY

List previous surgeries, diseases with dates:

_____

Allergies to any medication: ( ) Yes ( ) No

_____

Past Illnesses: _____

Have you ever been treated by a Chiropractor before ( ) Yes ( ) No If yes, Who? _____

_____

Have you been treated for any health condition by a physician in the last year? _____

_____

Check (x) for condition/symptoms you have or have had.

- ☐ Difficulty sleeping
- ☐ Stroke
- ☐ Diarrhea
- ☐ Constipation
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Fractures
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Herniated Disc
- ☐ Pacemaker
- ☐ Persistent cough
- ☐ Tiredness
- ☐ Headache
- ☐ Bronchitis
- ☐ Fainting
- ☐ Blurred vision
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Chest pain
- ☐ Pain Over Heart
- ☐ Difficult breathing
- ☐ Ulcers
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Lung problems
- ☐ Osteoporosis
- ☐ Bleeding disorders
- ☐ Tumors
- ☐ Cancer
- ☐ Diabetes
- ☐ Aids/HIV

How did you hear about us? _____

Agreement

I certify that I have read and understand the above information to the best of may knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. Should it be necessary to take action to collect any amount owing under this agreement. I will be responsible for all attorneys, collections fees, and any other costs incurred in collecting the amount owed.

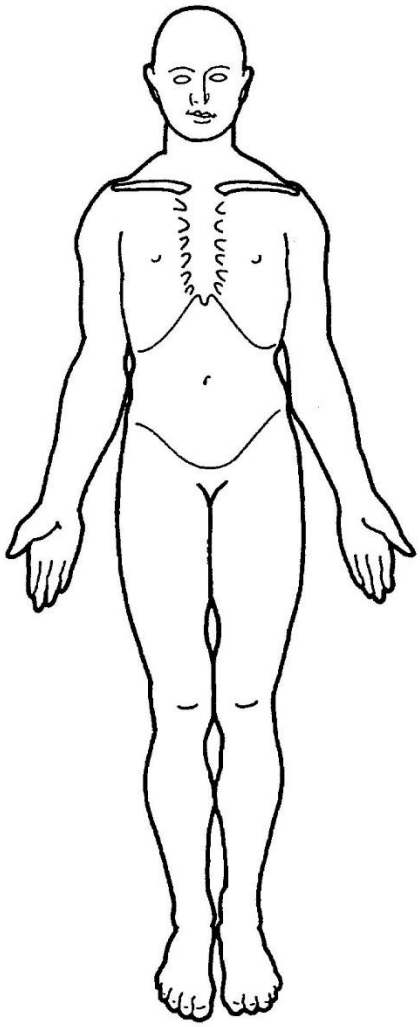
X _____ _____

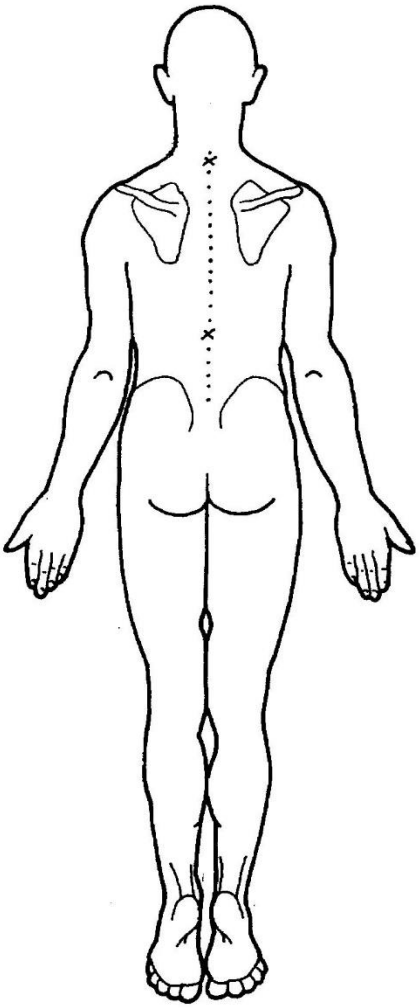
Patient Signature (Parent/Guardian if minor) **Date**

Acct#: _____ Name:_____ Date:_____

Mark (X) on the picture where you feel pain

Marque (X) donde siente dolor





What does your pain feel like? Please check all that apply.

( ) Stiffness ( ) Ache ( ) Numbness ( ) Tingling

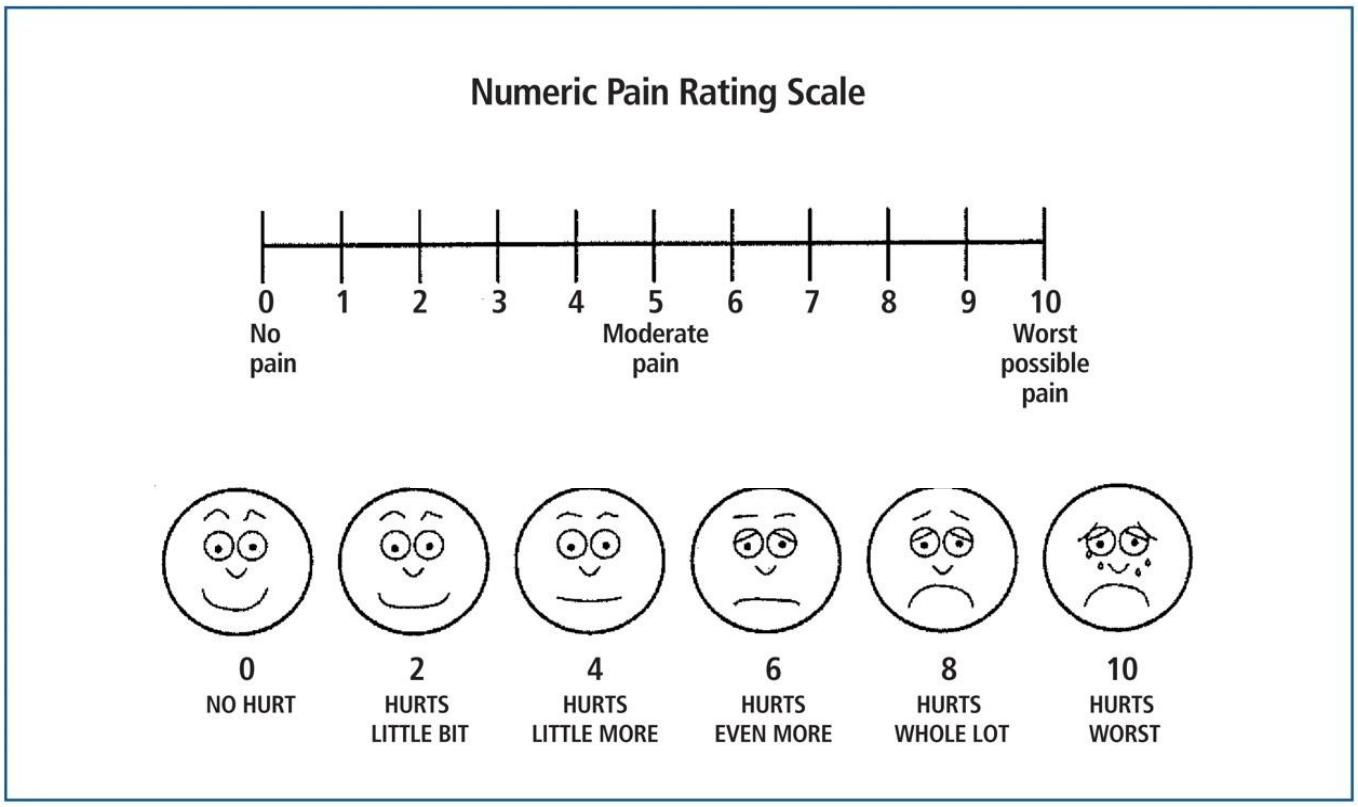
( ) Burning ( ) Stabbing ( ) Pins/Needles

Patient's Signature_____ Date_____

Patient Name:_____ Date:_____

Please indicate how much pain you have:

In order to check how your treatment is progressing – your Doctor will often ask you to rate your pain level on this diagram/scale from Zero **(0)** to Ten **(10)**. A rating of Zero **(0)** means you feel **NO pain**; five **(5)** means you feel a **moderate** amount of pain and ten **(10)** means you feel the **severe/worse** pain imaginable. **PLEASE CIRCLE THE NUMBER, YOU FEEL THAT BEST DESCRIBES YOUR PAIN LEVEL.**



Por favor indicar cuanto dolor está sintiendo:

De manera que nosotros sepamos cuanto mejoramiento usted ha tenido en su tratamiento – el Doctor le va a pedir que califique cuanto dolor usted está sintiendo. En este diagrama usted tiene que calificar su dolor en un nivel de cero (0) al diez (10). Si usted califica cero (0) indica que **no tiene dolor**, cinco (5) indica que tiene dolor **moderado** y diez (10) que tiene un dolor **insoportable**. **FAVOR DE CIRCULAR EL NÚMERO INDICADO.**

_____ _____

Patient's Signature **Date**

Patient's Name:_____

Date:_____

I hereby authorize: _____to make payment directly to:

Painfree Chiropractic & Rehab

6121 Lincolnia road suite 100
Alexandria, VA 22312
703.270.9020

The expense benefits allowable - and otherwise payable to me under my current insurance policy toward the total charges for professional services rendered by this clinic.

I authorize this clinic to release any information pertinent to my case/injury to any insurance company, adjuster, doctor and attorney involved in this case. I hereby release this clinic, Painfree Chiropractic & Rehab, of any consequence thereof.

I understand that I am financially responsible for all charges incurred at this clinic including any and all deductible, co-payment and co-insurance. Should it be necessary to take legal action to collect any amount owing under this agreement. I will be responsible for all attorney, collection fees, and other costs incurred in collecting the amount owed.

X_____ _____
Patient Signature/Guardian Date

X_____ _____
Print Name Date

Note: Parent or Guarding must sign for a MINOR CHILD

Painfree Chiropractic & Rehab
6121 Lincolnia Road, Suite 100
Alexandria, VA 22312
703.270.9020

TERM OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such case, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.
Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
Health: A state of optimal physical, mental and social wellbeing, not merely the absence of disease or infirmity.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease. We diagnose vertebral subluxation and/or neuro-musculoskeletal conditions. However, if during the course of a chiropractic examination, if there are unusual findings, we will advise you. If you desire advice, diagnosis or treatment of those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advise regarding treatment prescribed by others. **OUR ONLY PRACTIC OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustment.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office gave been answered to my complete satisfaction.
I therefore accept Chiropractic care on this basis.
Signature: _____ **Date**:_____

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.
Signature: _____ **Date**:
_____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform and x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

Signature: _____ **Date**: _____

NOTICE OF PRIVACY PRACTICES

0.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 Federal Privacy Rule,45 CFR oarts 160 and 164(the "Privacy Rule") and applicable state laws, is committed to maintaining the privacy of your protected health information("PH"I . PHI includes information about your health condition and the care treatment you receive from the Practice and is often referred to as your health care of medical record. This Notice explains how your PHI may be used and disclosed to third parties. This notice also details your rights regarding your PHI.

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:

(a)Treatment – To provide you with the health care you require, the Practice may use and disclose your PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan and manage your health care. For example, a chiropractor treating you for lower back pain may need to know and obtain the results of your latest physician examination or last treatment plan. (b) **Payment- – To get paid for** services provided to you, the Practice may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including, insurance companies and health plans. If necessary, the Practice may use your PHI in other collection efforts with respect to all persons who may be liable to the Practice for bills related to your care. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment time.

(c)Health Care Operations – To operate in accordance with applicable law and insurance requirements, and to provide quality and efficient care, the Practice may need to compile, use and disclose your PHI. For example, the Practice may use your PHI to evaluate the performance of the Practice's personnel in providing care to you.

Other EXAMPLES OF HOW the Practice May Use Your PHI:(a) Advice of Appointment and Services – from time to time, contact you to provide appointment reminders. The following appointment reminders may be used: a) a postcard mailed to you at the address provided by you; and b) telephoning your home/ leaving a message on your answering machine or with who answers the phone. (b) Directory/Sign-In Log – we maintain a sign-in log at its reception desk for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices. © **Family/Friends**- The practice may disclose to a family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care. We may also use or disclose your PHI to notify or assist in the notification(including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply: i) If you are present at or prior to the use or disclosure of your PHI, the practice may use or disclose your PHI if you agree, or if the practice can reasonably infer from the circumstances, based on the exercises of its professional judgement, that you do not object to the use or disclosure.(ii) If you are not present, the practice will, in the exercise of professional judgement, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

OTHER USE & DISCLOSURES WHICH MAY BE PERMITTED OR REQUIRED BY LAW

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

(a)De-identified Information –health information that may be related to your care but does not identify you and cannot be used to identify you. **b)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 information. **©Personal Representative** –to a person who, under applicable law, has the authority to represent you in making decisions related to your health care . **d) Emergency Situations** –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 PIII 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. **(e)Public Health Activities**–when required by law to provide information to a public health authority to prevent or control disease. **(f)Abuse, Neglect or Domestic Violence** –when authorized by law to provide information if it believes that the disclosure is necessary to prevent serious harm.**g)Health Oversight Activities** – We may use and disclose PHI when required by law to provide info. in criminal investigations, disciplinary actions, or other activities relating to the community's health care system.**(h)Judicial and Administrative Proceeding** –in response to a court order or a lawfully issued subpoena. **(i)Law Enforcement Purposes** –, when authorized, to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena,or if the Practice believes that your death was the result of criminal conduct.**(j)Coroner or Medical Examiner** –to a coroner or medical examiner for the purpose of identifying you or determining your cause of death. **k)Organ, Eye or Tissue Donation** -- The Practice may use and disclose PHI if you are an organ donor to the entity to whom you have agreed to donate your organs.**(l)Research** – The Practice may use and disclose PHI subject to applicable legal requirements if the Practice is involved in research activities.**m)Avert a Threat to Health or Safety** – The Practice may use and disclose PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or **the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat**.**(n)Specialized Government Functions** –when authorized by law with regard to certain military and veteran activity. **o)Workers' Compensation** – The Practice may use and disclose PHI if you are involved in a Workers' Compensation claim to an individual or entity that is part of the Workers' Compensation system.**p) National Security and Intelligence Activities** –to authorized governmental officials with necessary intelligence information for national security activities **(q)Military and Veterans** –if you are a member of the armed forces, as required by the military command authorities. Authorization

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

You have the right to:(a)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(b)Request special restrictions on certain uses and s disclosures of your PHI as authorized by law. In general, this relates to your right to request special restrictions concerning disclosures of your PHI regarding uses for treatment, payment and operational purposes under Privacy Rule, Section 164.522

(a) and restrictions related to disclosures to your family and other individuals involved in your care under Privacy Rule, Section 164.510 (b). Except in certain instances, the Practice may not be obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment. (c)Receive confidential communications or PHI by alternative means or at alternative locations as provided by Privacy Rule Section 164.522(b). For instance, you may request all written communications to you marked "Confidential Protected Health Information." You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests. d)Inspect and copy your PHI as provided by federal law (including Privacy Rule, Section 164.524) and state law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.(e)Amend your PHI as provided by federal law (including Privacy Rule, Section 164.526) and state law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.(f)Receive an accounting of disclosures of your PHI as provided by federal law (including Privacy Rule Section 164.528) and state law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred. (g)Receive a paper copy of this Privacy Notice from the Practice (as provided by Privacy Rule Section 164.520(b)(1)(iv)(F)) upon request to the Practice's Privacy Officer. (h)Complain to the Practice or to the Secretary of HHS (as provided by Privacy Rule Section 164.520(b)(1)(vi)) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights(as provided by Privacy Rule Section 164.520(b)(2)(vii)), you may contact the Practice's Privacy Officer as follows: **Name: Mohammad Yousefi at 9200 Colesville Road Silver Spring, MD 20910 Phone#: 301-585-3200**

PRACTICE'SREQUIREMENTS

a)Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
(b)Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
(c) The practice is required to abide by the terms of this Privacy Notice
d)Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
e)Will distribute any revised Privacy Notice to you prior to implementation.
(f)Will not retaliate against you for filing a complaint.

Effective Date This Notice is in effect as of 04/15/03.

PATIENT ACKNOWLEDGEMENT By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.