WELCOME TO PIDCOCK CHIROPRACTIC

You are about to experience the most popular alternative health care in the world!

Below is a short description of Chiropractic and how it works.

Chiropractic care is a natural approach to healthcare. The body is a machine powered by the nervous system. The brain is the main “computer” which is connected to your spinal cord. The spinal cord is a long wire that runs from your brain to your tail bone. The brain is protected by the skull and the spinal cord is protected by 24 moveable backbones, “vertebrae”. Nerves branch off the spinal cord like smaller wires and pass between the backbones. These nerves control the functions and sensations “pain”, in every organ, tissue and system in your body. Sometimes the bones in your back can move out of their normal positions and put pressure on nerves causing pain or an organ to function improperly. This condition is known as a “Subluxation”. Chiropractors are the only Doctors who are trained in locating and correcting subluxations.

The way Dr. Pidcock locates subluxations is by first feeling the bones to see if they have moved out of their normal positions. Second, he may take an x-ray to see exactly how much the bones have moved. Once the subluxations are located, Dr. Pidcock will begin to put the bones back into their normal positions very gently with his hands. The process is painless and the benefits are enormous.

Subluxations left untreated may result in permanent damage. First, the bones out of place cause the spine to move improperly. Second, the nerves with pressure on them begin to deteriorate. Third, the muscles around the area are irritated and begin to spasm. Fourth, the cells that the nerves go to begin to function improperly. Finally, the bones out of place become arthritic, the discs between the bones begin to degenerate, and the joints can no longer function. When this occurs, permanent nerve damage may occur and surgery may be the only answer.

How do subluxations occur? Subluxations occur when there is any type of stress on a person. Physical stress such as accidents and falls are the leading cause. Mental stress such as depression can cause subluxations as well. Irregular sleep patterns and everyday movements may also cause subluxations.

What kind of symptoms will people with subluxations have? Most patients come to Dr. Pidcock for lower back, shoulder, middle back, neck, arm, leg, hand, and foot pain. Others may even complain of headaches, arthritis, and bursitis. Still others seek Chiropractic care for a variety of other ailments. Ask Dr. Pidcock if he can help a specific condition. It is important to realize that subluxations do not always hurt. Most patients with subluxations will not have any pain at all! The only way to be sure that someone is subluxation-free is to have Dr. Pidcock examine them. Dr. Pidcock recommends that all of his patients bring their families in for a free exam to check them for subluxations.

APPLICATION FOR TREATMENT

PERSONAL INFORMATION

Name: ______________________ Today's Date: ____/____/____

Address: ______________________

E-mail Address: ______________________

Birth Date: __/__/__ Age: ______ Are you Pregnant: ❒ Yes ❒ No

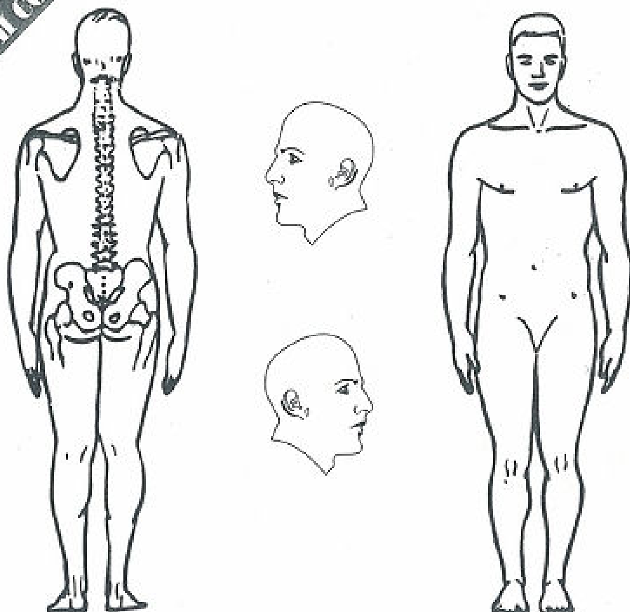
Employer's Name & Address: ______________________

Occupation: ____________ Work Phone No.: ____________ Home Phone No.: ____________

What type of care do you desire: ❒ Temporary Relief ❒ Lasting Correction ❒ Best Care Possible

CURRENT HEALTH CONDITION

Please circle the exact location of any pain you are experiencing. Then describe the type of pain, i.e. dull, sharp, constant, on & off, etc.



In order of importance, list the health problems you are most interested in getting corrected:

1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________

In order of severity, list those body functions that you are unable to perform, or that produce pain upon performance, i.e. walking, sitting, bending, etc.

1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________

When was the first time you noticed this problem:

____

____

Describe any accidents, falls, injuries, sudden movements, etc. that may have caused your problem: ______________________

____

Have you had any similar health problems or injuries before? ❒ Yes ❒ No If yes, please explain: ____________

____

Names of all other doctors you have seen for this problem: ______________________

____

Diagnosis and type of treatment you received (please include where and when you received treatment, and the results):

____

____

Has your health problem been: ❒ Improving ❒ Worsening ❒ Staying the Same

Please describe anything you do that improves your condition, or worsens it: ______________________

____

Please check off and describe how this problem interferes with your work and/or personal life:

❒ Home Activities Effected: ______________________

❒ Work Activities Effected: ______________________

Have you missed any work days? ❒ Yes ❒ No If yes, dates missed: ______________________

❒ Recreational Activities Effected: ______________________

❒ Rest or Sleep Effected: ______________________

(Please complete reverse side.)

PREVIOUS HEALTH HISTORY

During the last year, has a doctor treated you for any health problem? ❒ Yes ❒ No

If yes, please explain: ______________________________

Have you ever received Chiropractic care? ❒ Yes ❒ No If yes, please list the doctor's name, location of office and for what problems: ______________________________

Please check off the drugs you are now taking: ❒ Pain Killers ❒ Muscle Relaxers ❒ Anti-inflammatory ❒ Blood Pressure Medication ❒ Insulin ❒ Birth Control Pills ❒ Tranquilizers ❒ Diet Pills ❒ Nerve Medication ❒ Sleeping Pills ❒ Anti-depressants ❒ Other (please list): ______________________________

List the approximate dates of any accidents, operations or serious injuries (including broken bones) you have had: ______________________________

If you have been in an automobile accident, when? ❒ This Year ❒ Last Year ❒ Past 5 Years ❒ Over 5 Years

Please check off the following that apply to you within the past 2 years: ❒ Went to a Health Spa ❒ Purchased Vitamins ❒ Purchased Health Foods ❒ Received a Massage

Please explain why you choose to do any of the above: ______________________________

FAMILY HEALTH HISTORY

Marital Status: ❒ Married ❒ Single ❒ Widowed ❒ Divorced ❒ Separated

Names & Ages of Children: ______________________________

Name of wife or husband: ______________________________

Spouse's Employer: ______________________________ Business Phone: ______________________________

FINANCIAL RESPONSIBILITY

Who is responsible for your bill? ❒ I am ❒ Spouse ❒ My Employer ❒ Insurance

❒ Other: ______________________________

Type of Insurance: ❒ Worker's Comp. ❒ Health ❒ Automobile

Insurance Company's Name & Address: ______________________________

If you are responsible for your health care fees, payment will be made by: ❒ Cash ❒ Check ❒ Credit Card

Your fees are due and payable at the time examinations, X-rays, and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic.

I, the undersigned, hereby give permission for treatment.

Patient's Signature ______________________________ Social Security No.: ______________________________ Date: ___/___/___

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PIDCOCK CHIROPRACTIC, Inc. **3009 Peach Orchard Rd. Augusta, GA 30906 Phone 706/798-8980**
Dr. Scott J. Pidcock, Chiropractor

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

USE AND DISCLOSURE OF INFORMATION

1. The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for lower back pain may need to know the results of your latest examination by this office.

(b) Payment – In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements. 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 properly 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 expense.

(c) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

2. The Practice may also use and/or disclose your PHI in the following instances:

(a) De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate – To a business associate 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 companies or other payers.

(c) 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 –

(i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your acknowledgment of our Privacy Notice as soon as possible; or

(ii) 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) Communication Barriers – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your acknowledgment of our Privacy Notice and the Practice determines, in the exercise of its professional judgment, that your consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.

(n) Avert a Threat to Health or Safety - The Practice may disclose your 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.

(o) Specialized Government Functions - This refers to disclosures of PHI that relate primarily to military and veteran activity.

(p) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(q) National Security and Intelligence Activities – The Practice may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.

(r) Military and Veterans – If you are a member of the armed forces, the Practice may disclose your PHI as required by the military command authorities.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

DIRECTORY/SIGN-IN LOG

The Practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are 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 your 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 or

the payment for your care. The Practice 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:

(a) 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 exercise of its professional judgment, that you do not object to the use or disclosure.

(b) If you are not present, the Practice will, in the exercise of professional judgment, 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.

AUTHORIZATION

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

YOUR RIGHTS

1. You have the right to:

(a) Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not 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. 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 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 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 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 upon request to the Practice's Privacy Officer.

(h) Complain to the Practice or to the Secretary of HHS 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.

(i) To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer.

PRACTICE'S REQUIREMENTS

1. The Practice:

(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) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the State statutes:

(c) 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 today.

By signing below, I acknowledge that I have received and reviewed the Pidcock Chiropractic, Inc. Privacy Notice and all of my questions have been answered to my satisfaction in language that I can understand.

______________________________	_________________________________
Name of Individual (Printed)	Signature of individual
_______________________________	__________________________________
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor):	Relationship
Date Signed ____/____/____	Witness:
_________________________________	

Personal Injury History Form

NAME: DATE:
Date of accident:
Where were you sitting?
Were you wearing a seat belt?
Was anyone else in your vehicle?
Did you go to the ER?
Were x-rays taken?

Tell me how the accident happened? **DIAGRAM**
How were you positioned at impact?
Did you hit your head?
Did you have any cuts or abrasions?
How fast were you going?
How fast was the other vehicle going?
What type of vehicle were you in?
What type of vehicle was the other?
How much damage to your vehicle?
How much damage to other vehicle?
Have you had previous accidents or injuries?
Are you taking any medications for any condition?
Have you ever had any type of surgery?
Where do you work?
What are your job duties?
Can I verify your home phone number?
What is your work number?
What is your cell or pager number?

Staff Use Below: Do not ask patient.
Date of birth: Date of accident:

Chief symptoms:

Past history: Non-contributing Previous accident

Exam: Decreased range of motion with pain: Cervical Thoracic Lumbar

Cervical compression elicited pain into the

Right shoulder Left shoulder

X-rays: Yes No

Diagnosis: Cervical sprain Thoracic sprain Lumbar sprain

Post traumatic cephalgia Post traumatic cervicobrachial syndrome

Other:____

ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY

To Whom It May Concern:

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to ______________________________(Office) such sums as may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reason of any other bills that due this Office, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me, or from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of settlement, judgement or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this Office for their services, refuses to make such payments, upon demand by me or this Office, I hereby assign and transfer to this Office any all causes of action that I might have that might exist in my favor against such company, and authorize this Office to prosecute said cause of action either in my name or in the Office's name, and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option. I further understand that any and all legal fees including collection service fees billed to this Office will be my responsibility over and above the fees incurred for services at this office.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

Date:______________________ Signed:______________________________