
I authorize Alternative Health Solutions, to contact me via the following methods:

- Home, including recorded message that another person may be retrieving
- Mail
- Cell
- Work

Exclusions: _____

Please note the names below of any person(s) that we are able to communicate with regarding general issues, non-medical in nature (i.e.: returning of calls, scheduling of appointments via spouse or an assistant, leaving a message with a roommate, etc.).

Other designated person(s): _____

This authorization is irrevocable until request of change is submitted in writing to A.H.S.

Patient Name (Printed)

Patient or Responsible Party (Signature)

Date

I authorize Alternative Health Solutions, to **discuss** my care with the following:

I authorize Alternative Health Solutions, to **request and/or release records to/or** from the following:

This authorization is irrevocable until request of change is submitted in writing to A.H.S.

Patient Name (Printed)

Patient or Responsible Party (Signature)

Date

FINANCIAL AGREEMENT

The purpose of this document is to detail and clarify the financial details regarding your care.

Fees and Services:

- Our fees are based on the area averages for the specific services rendered. The severity of your condition coupled with the amount of time needed for you to reach your health goals will determine the amount and types of services that you will receive. _____
initials
- All services are rendered, charged and collected in full from you the patient (or if a minor, the responsible party) at the time of service. _____
initials
- We will not file or accept payment from your insurance company. _____
initials
- If you have insurance coverage and wish to request reimbursement for the service, documentation is provided to you at the time of service. You will need the documentation to file the claim. It is recommended that you contact your insurance company to determine the most expedient method for reimbursement. _____
Initials
- All product will be charged and collected, in full, at the time of purchase. _____
initials
- We reserve the right to collect a fee for missed appointments. We reserve the right to collect a fee for appointments canceled within 24 working hours of the scheduled appointment. This is out of courtesy for other patients who are in need of care and may be waiting for an available appointment. _____
initials

Methods of Payment: (to be made in full at the time services are rendered)

We accept the following methods of payment:

- Cash
- Personal Checks
- Credit Cards – Visa, MasterCard, Discover, American Express
- Personal Injury Programs

Important: You have employed your insurance company to work for you. We will not become involved in any disputes between you and your insurance company regarding, but not limited to, deductibles, covered charges, secondary insurance, “usual and customary” charges, etc. We will however supply you with factual information, when requested for your communication with your insurance company.

Patient Agreement: I have read this agreement, been given the opportunity to ask questions and understand the agreement. I also understand that I am fully responsible for all financial obligations incurred. (A copy of this signed agreement is provided to the signer.)

Responsible Party (Signature)

Patient Name (Printed)

Date

Clinic Representative

Date

Introduction to Patient Care

- First Step:** A no-charge 40 minute consultation with the doctor to discuss your health concerns. At this time the doctor will determine if she is able to accept you as a new patient, that our care and treatment is appropriate for you at this time. If yes, an exam is scheduled.
- Second Step:** As a new patient we request that you complete confidential, personal and health history information that complies with the HIPPA regulations protecting your privacy.
- Third Step:** A complete and comprehensive examination including any chiropractic, neurological, orthopedic, and physical tests needed to determine the exact cause of your problem. After evaluation of the exam findings, the doctor will advise you if any additional tests including x-rays or laboratory tests are needed.
- Fourth Step:** The doctor will review all of the findings and generate a report to present to you at the next visit. This visit is called the Report of Findings. At the visit the specific cause(s) of your problem will be discussed in detail. The doctor will explain how and why **chiropractic neurology** works. As part of the report a customized treatment plan will be designed for you. This may include chiropractic adjustments, neuro-musculo-skeletal reeducation and/or customized nutritional protocols. The doctor will give you an estimate of how long it will take to achieve your health goals and how optimum results can be obtained. Treatment begins as part of this visit.
- Fifth Step:** Your future visits are scheduled based upon the doctor recommended treatment plan, designed for you to reach your health goals. You are now on the path to wellness. **WELCOME!**

YOUR HEALTH IS YOUR MOST VALUABLE ASSET

We applaud you for taking the steps to regain it!



Alternative Health Solutions

NOTICE OF PRIVACY PRACTICES

Please read this carefully. It concerns your individual, private healthcare information and how this information may be used and disclosed by this office and how you can get access to this information. Please review it carefully.

- 1) We have a legal, ethical and moral obligation to protect your confidentially. Any information about you and/or your family will be held strictly confidentially by all employees. No discussions about you outside of the patient care framework will be allowed, and any conversation between staff members that pertains to delivering you quality care will be held in a confidential and professional manner.
- 2) In order to provide quality care to you, as well as operate this office in an efficient manner, we will need to access your private health care information for the purposes of treatment, payment and operations (such as quality assurance). In using this information this office will comply with all state and federal laws pertaining to your privacy rights, including the Privacy and Security protections provided to you by the Health Insurance Portability and Accountability Act (“HIPPA”).
- 3) Specifically, we will need to disclose your private information under the following circumstances:
 - a) **Sharing information for purposes of treatment:** We will share information with all members of your treatment team, both within this office and with other providers (personal and Institutional) in order to provide you with the quality care and the education/wellness programs.
 - b) **Sharing of information for the purposes of payments:** We will share all necessary information with your insurer(s), payor(s), governmental entities (such as Medicare, Medicaid, Americade, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as our representatives involved in the billing process (including, but not limited to claims representatives, data warehouses, billing companies, etc.).
 - c) **Sharing of information for purposes of operations:** We will share all information necessary for ongoing operations of this office, including (but not limited to) credentialing processes, peer review, accreditation and compliance with all federal and state laws.

- 4) Your consent for use and disclosure of information as described may be revoked in writing at any time. Please notify the office/Privacy Officer if you ever decide to revoke your consent.
- 5) Your specific authorization will be required for the release of any information not included above. Your authorization will need to be in writing and it will be specific to the disclosure requested.
- 6) This office will not release any information other than those incidents described above unless disclosure is required by law, a court, a legal process or government agencies.
- 7) You have the right to inspect and copy your protected information, amend your record, have reasonable requests for confidential communications accommodated and may obtain an accounting of disclosures. All other rights afforded to you by state and federal law will be honored as they are created. This office will attempt to comply with any of your requests if feasible. Please contact the Privacy Officer if you have any questions about your rights, or with any other privacy related questions you may have.
- 8) This office will continue to respect you and your family's privacy and confidentiality. The Privacy Officer is available to discuss any questions or concerns you may have regarding the security and privacy of you and/or your family's private health information.

Consent to Services and Treatment

Consent to Treatment of a Minor Child **Initials** _____

I authorize the licensed doctor and whomever he/she may designate as assistants to administer care to my _____ (relationship), _____ (name).

Female Patients **Initials** _____

This is to certify that to the best of my knowledge I am NOT pregnant and that Alternative Health Solutions has permission to take x-rays.

Beginning date of your last menstrual period _____

Consent to Services and Treatment **Initials** _____

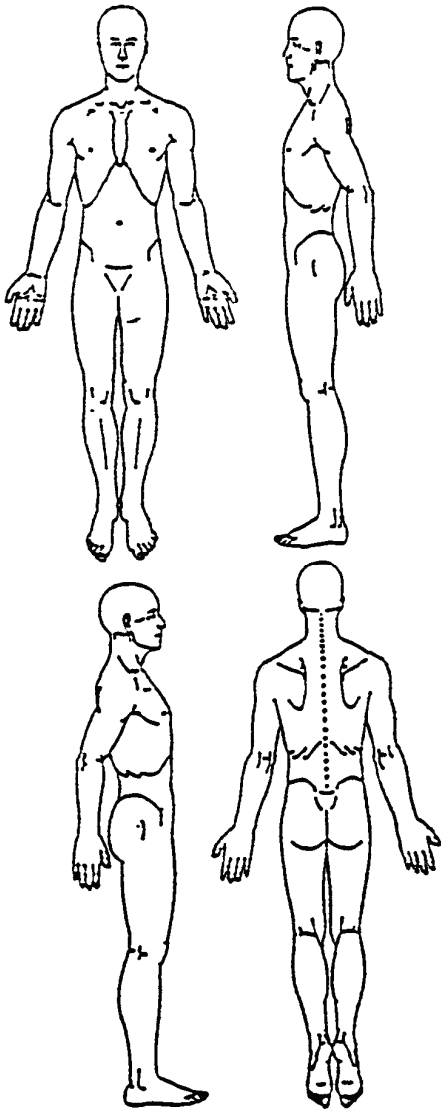
I authorize the performance of diagnostic and therapeutic procedures, whether or not arising from presently unforeseen conditions, that the clinician(s) may consider necessary or advisable in the course of my health care. I understand there are fees for these services for which I am responsible. These charges will be explained to me upon my request.

The below signature serves as signature on file for the year of 2007.

Patient Name _____
(Print)

Signed _____ **Date** _____
(Patient or Patient's Guardian)

Witness _____ **Date** _____
(Alternative Health Solutions Representative)



Please use the following guide to help you accurately mark all of the areas of your body affected by the described sensations.

Please use the appropriate symbols to indicate all affected areas.

DULLNESS: D D D

STABBING/CUTTING: SC SC

BURNING: B B B

TINGLING: T T T

CRAMPING: C C C

NUMBNESS: N N N

Have you ever had Chiropractic Care? Y N

Are you familiar with the specialty of Chiropractic Neurology? Y N

Are you here due to a sports injury? Y N

Are you interested in health & wellness? Y N

Are you needing nutritional guidance? Y N

COMMENTS: _____

Patient Signature: _____ Date: _____

Confidential Patient Health Record

How did you find us?

Patient Name _____ Minor: Y N
Address _____ City _____ State _____ Zip _____
E-mail Address _____ Home Tel # _____
Cell # _____ Date of Birth _____ Age _____ Sex _____ SS # _____
 Married Single Widowed Divorced Occupation _____ Employer _____
 F/T P/T Employer Address _____ Work Phone / Ext. _____

Emergency Contact Name _____ Telephone # _____

Name of Spouse _____ Date of Birth _____ SS # _____
Employer & Address _____ Work Phone / Ext. _____

If Minor - Responsible Party _____ Address _____
City/State/Zip _____ E-mail Address _____
Home Tel # _____ Work Phone / Ext. _____
Cell # _____ Date of Birth _____ Age _____ Sex _____ SS # _____

Health Condition and History

Injury? Y N Auto On-the-Job Date _____ Time _____ AM PM Was Injury / Accident Reported? Y N
Reason For Appointment _____
When Did This Condition Begin? _____ Has This Condition Occurred Before? Y N
Have you had treatment for this condition? Y N Type of Treatment _____
Performed By _____ City / State _____ Phone # _____
Date of Last Visit _____ Results _____
Medications You Are Currently Taking: Pain Killers/ Muscle Relaxers Blood Pressure Med's Thyroid Med's Insulin Birth Control
 Hormones Anti-depressants Other: _____
Other Conditions You Suffer From _____
Primary Care Physician _____ City / State _____
Phone # _____ Previous Chiropractic Care? Y N Date of Last Visit _____
Doctor's Name _____ City / State _____
Phone # _____ Past injuries, accidents, hospitalizations and dates _____

If needed use back of form for additional information

To be completed by A.H.S. Staff Primary Dr. _____ Date of 1st visit _____ File # _____

Dear Valued Patient,

Due to new government regulations it is necessary to inform you of our privacy practices. Our office has always protected and guarded your privacy and your personal health information. We will continue to do so in the same respectful manner. Thank you for placing your trust in us.

Sincerely,
Alternative Health Solutions

- I have received a copy of the "Notice of Privacy Practices" which details my rights of privacy.
- I consent and authorize Alternative Health Solutions, to utilize my PHI (Private Health Information), for health/wellness and treatment purposes as well as for internal administrative purposes.
- I consent and authorize the releasing of my PHI from Alternative Health Solutions to another service organization in direct regard to my health/wellness and treatment being performed by Alternative Health Solutions.
- I consent and authorize Alternative Health Solutions to discuss, document, provide and/or request PHI to/from another organization for means of collection of payment or reimbursement.
- I consent and authorize Alternative Health Solutions to discuss, document, provide and/or request PHI from another organization for administrative purposes.
- I have the right to deny and/or limit the use of my PHI. Should my requests and or choices affect my care as deemed necessary by the doctor, I understand that I may be released as a patient of Alternative Health Solutions.

Patient Name (printed) _____

Responsible Party (signature) _____

Date _____

Witnessed (AHS) _____

Date _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

INTAKE: Coffee Cigarettes / Tobacc Tea Alcohol Soda Pain Relievers Antacids

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Anemia	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Mental Disorders
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Measles	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Influenza (Flu)	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Polio	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Eczema
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> HIV + / AIDS	<input type="checkbox"/> Hepatitis / Liver Disease
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Other: _____				

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD THE LAST 6 MONTHS:

MUSCULO-SKELETAL

<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Pain between Shoulder:	<input type="checkbox"/> Shoulder / Arm / Hand Pain	<input type="checkbox"/> Walking Problems	<input type="checkbox"/> General Stiffness
<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Joint Pain / Stiffness	<input type="checkbox"/> Difficulty Chewing / Clicking Jaw	<input type="checkbox"/> Grinding / Popping in Joints

NERVOUS SYSTEM

<input type="checkbox"/> Numbness	<input type="checkbox"/> Weakness	<input type="checkbox"/> Dizziness / Light-headed	<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Depression	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Stress
<input type="checkbox"/> Tingling Sensation	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Confusion	<input type="checkbox"/> Fainting	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Tremor

GENERAL

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Allergies	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Headaches	<input type="checkbox"/> Fever	<input type="checkbox"/> Sleeping Problems
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GASTRO-INTESTINAL

<input type="checkbox"/> Poor / Excessive Appetite	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Abdominal Problems	<input type="checkbox"/> Gas / Bloating after Meal
<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Colitis	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Frequent Nausea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Gallbladder Problems	<input type="checkbox"/> Weight Trouble	<input type="checkbox"/> Black / Bloody Stool

GENITO - URINARY

<input type="checkbox"/> Bladder Trouble	<input type="checkbox"/> Painful / Excessive Urination	<input type="checkbox"/> Discolored Urine
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MALES ONLY

<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Erection/Ejaculation Difficulties	<input type="checkbox"/> Genital Infection / STD	<input type="checkbox"/> Lump in Testicles	<input type="checkbox"/> Breast Lump
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C-V-R

<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Blood Pressure Problems	<input type="checkbox"/> Pounding Heart	<input type="checkbox"/> Lung Problems / Congestion	<input type="checkbox"/> Ankle Swelling
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Cold Extremities

EENT

<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Dental Problems	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Persistent Cough
<input type="checkbox"/> Hearing Difficulty	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Stuffed Nose	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Facial or Sinus Pain

FEMALES ONLY

<input type="checkbox"/> Menstrual Irregularity	<input type="checkbox"/> Menopause	<input type="checkbox"/> Painful intercourse	<input type="checkbox"/> STD
<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Vaginal Pain / Infection	<input type="checkbox"/> Discharge: Nipple or vagina	<input type="checkbox"/> 1st Day of Your Last Period: _____
<input type="checkbox"/> PMS	<input type="checkbox"/> Breast Pain / lumps	<input type="checkbox"/> Abnormal Pap Smear	<input type="checkbox"/> Date of Last Pap Smear: _____