REGISTRATION INFORMATION

First Name:_____ Middle Initial: _____ Last Name: _____ Sex: M / F

Date of Birth:_____ Phone: (H) _____ (W)_____ (C)_____

Address: _____

E-Mail:_____ Social Security #:_____-_____-_____ Married: Y / N

Spouse Name: _____ Employer Name: _____

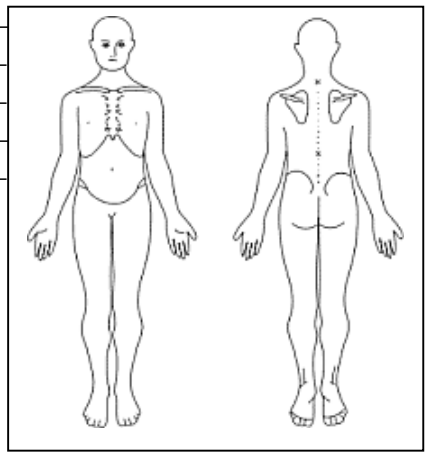
Primary Physician: _____ Was this an auto accident or work related injury? Y / N

Insurance Company: _____ Subscribers Name: _____

Subsciber ID:_____ Group #: _____ Claim #_____

HEALTH STATUS

Mark where you have pain or other symptoms.



Describe your current problem:_____

_____

_____

Date Problem Began:_____How did it happen?_____

_____

Please rate your pain today: **0 1 2 3 4 5 6 7 8 9 10**
No pain Unbearable

How often:
(Occasional) **0-25%** **26-50%** **51-75%** **76-100%** (Constant)

Your overall health is:
O **Excellent** O **Very Good** O **Good** O **Fair** O **Poor**

Have you had spinal X-Rays, MRI, CT Scan or other imaging?: Y / N

Other treatment for this condition?: Y / N By Whom?: _____ **When?:**_____

Who Referred You? O **Yellowpages** O **Website** O **Physician:** _____ O **Other:** _____

Please check all of the following that apply to you:

O Alcohol / Drug dependence
O Recent Fever
O Diabetes
O High Blood Pressure
O Stroke (date) _____
O Arthritis (rheumatoid /osteoarthritis)
O Taking Birth Control
O Dizziness / Fainting
O Numbness (where?) _____
O Cancer / Tumor (explain) _____
O Osteoporosis
O Epilepsy /Seizures

O Prostate CA / Problems
O Menstrual Problems (explain) _____
O Urinary Problems
O Currently Pregnant (# weeks) _____
O Abnormal weight Gain or Loss
O Marked Morning Pain / Stiffness
O Pain Unrelieved by Position or Rest
O Visual Changes (explain) _____
O Surgeries _____
O Tobacco Use (how often) _____
O Medications _____
O Other: _____

Family History:
O Cancer O Diabetes O High Blood Pressure O Heart Problems / Stroke O Rheumatoid Arthritis
O Other: _____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature:_____ **Date:** _____

Kent Island Chiropractic And Rehabilitation
NOTICE OF PRIVACY PRACTICES
CONSENT FOR TREATMENT
FINANCIAL POLICY

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.

Kent Island Chiropractic And Rehabilitation (K.I. Chiro and Rehab) is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices, with respect to your protected health information.

Disclosure of Your Health Care Information…

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (Example)
"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with K.I. Chiro and Rehab." "It is our policy to provide a substitute health care provider, authorized by K.I. Chiro and Rehab to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)
"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to K.I. Chiro and Rehab for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing which you may submit to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information in the event of an emergency or of your death to a family member or another person responsible for your care.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.
We may contact you for marketing purposes or fundraising purposes, as described below: (example)
"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time."

Change of Ownership

In the event that K.I Chiro and Rehab is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that K.I. Chiro and Rehab is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that K.I. Chiro and Rehab amend your protected health information. Please be advised, however, that K.I. Chiro and Rehab is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

K.I. Chiro and Rehab reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, K.I. Chiro and Rehab is required by law to comply with this Notice. K.I. Chiro and Rehab is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Mary Zonetti by calling this office at (443) 249-3168.

Complaints

Complaints about your Privacy rights, or how K.I. Chiro and Rehab has handled your health information should be directed to Mary Zonetti by calling this office at (443) 249-3168. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:
DHHS, Office of Civil Rights,200 Independence Avenue, S.W. Room 509F HHH Building, Washington, DC 20201
This notice is effective as of 01/01/2009.

Financial Policy

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to KI Chiro & Rehab.will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be due and payable. I also understand that as a courtesy to me, KI Chiro & Rehab will keep track of the requirements set forth by my insurance company (i.e., pre-authorizations, referrals, and or treatment plans). However, it is ultimately my responsibility to keep track of these requirements and verify that they are up to date prior to treatment.

Consent for Treatment

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Techniques and Physical Therapy Modalities, and I give authority for these procedures to be performed. It is understood and agreed that there are inherent risks associated with these forms of treatments and they will be disclosed to me during my examination (prior to receiving treatment).

I have read the Privacy Notice, Consent for Treatment and Financial Policy. I clearly understand my rights contained in this notice.

_____
Patient's Name (print)

_____/ _____
Patient's Signature / Date