ROSE
Chiropractic, Inc.

Welcomes YOU!

Appointment Reminders (please circle)
phone / text / email / none

1 ABOUT YOU

Today's Date:_____ File #:_____
Patient Name:_____
LAST FIRST MI
What You Prefer To Be Called:_____ Male_____ Female_____
Birthdate:_____ Age:_____ SS#:_____
Mailing Address:_____
CITY STATE ZIP
Home Phone #:_____ Work Phone #:_____
Cell Phone #:_____ E-Mail Address:_____
Referred By:_____
Employer:_____ How Long?_____
Employer's Address:_____
CITY STATE ZIP
Occupation:_____
Status: Minor___Single___Married___Divorced___Separated___Widowed___
Spouse's Name (if applicable):_____
Do you have children? Yes___No___ If yes, how many?_____

2 INSURANCE INFO

Company Name:_____
Address:_____
CITY STATE ZIP
Phone #:_____ Insured's SS#:_____
Group #:_____ ID#:_____
Insured's Name:_____ Relation:_____ Date of Birth:_____
Insured's Employer:_____
(Please inform front desk of second insurance source.)

3 ACCOUNT INFO

(Person ultimately responsible for account.)
Name:_____ Relation:_____
Billing Address:_____
CITY STATE ZIP
SS#:_____
Driver's License#:_____ Work Phone#:_____
Payment Method:___CASH___CHECK___CREDIT CARD

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
(Customer's Initials)_____

4 REASON FOR VISIT

The reason for this visit is a result of (Please circle): work, sports, auto, trauma or chronic.
(Explain what happened):_____
Please describe the pain and its location:_____
When did condition begin?_____
Is this condition getting worse?___Yes___No___Constant___Comes and goes
Is this condition interfering with your (Please circle): work, sleep or daily routine.
If so please explain:_____
Have you had this or similar conditions in the past?___Yes___No
If so, please explain:_____
Have you been treated by a Medical Physician for this condition?___Yes___No
If so, where?_____
Have you ever been treated by a Chiropractor before?___Yes___No
If so, whom?_____ Phone#:_____

Please continue on back....

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continued...

5 IN EVENT OF EMERGENCY

IN EVENT OF EMERGENCY

Who should we contact? _____
Relation: _____
Home Phone #: _____
Work Phone #: _____
Who is your Medical Doctor? _____
Phone #: _____

6 HEALTH HISTORY

HEALTH HISTORY

Are you taking any of the following medications? _____
Nerve pills___Pain killers (including aspirin)___Muscle relaxers___Stimulants___Blood thinners
Tranquilizers___Insulin Other(s)_____
Do you have or have you had any of the following diseases or conditions? (Please circle "Y" or "N")

Y N Heart Attack/Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol/Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+/Aids	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes/Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones/Joints	Y N Arthritis

Please list any other serious medical condition(s) you have or ever had: _____
_____
Please list anything that you may be allergic to: _____
_____
List previous surgeries/treatments with dates: _____
_____
List any past serious accidents with dates: _____
_____
Family Health History: _____
_____
Do you: Take Supplements or Vitamins?___Yes___No Exercise?___Yes___No
Are you on a special diet?___Yes___No Since: _____
Do you smoke?___Yes___No How Much?_____How long?_____
Are you wearing:___Heel Lifts___Sole lifts___Inner soles___Arch supports
What is the age of your mattress?_____Is it comfortable?_____
For women: Are you taking Birth Control?___Yes___No
Are you Pregnant? ___Yes___ No How Long?_____Nursing? ___Yes__ No

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the physician. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____
Responsible Party

2941-B Zelda Road • Montgomery, AL 36106 • Office (334) 264-7948

ROSE
Chiropractic, Inc.
P.O. Box 230427
Montgomery, AL 36123-0427

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

CHIROPRACTIC
It is important to acknowledge the differences between the healthcare specialties of Chiropractic, Osteopathy and Medicine. Chiropractic healthcare seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic healthcare services.

ANALYSIS
A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS
Although Doctors of Chiropractic are experts in Chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a Chiropractic adjustment, or healthcare, if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in you healthcare regime.

RESULTS
The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond to Chiropractic care may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

TO THE PATIENT
Please discuss any questions or problems with the Doctor **before** signing this statement of policy.

I have read, and understand the foregoing;

_____ _____
PATIENT/LEGAL REPRESENTATIVE DATE SIGNED

ROSE
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Montgomery, AL 36123-0427

Office Policy Procedures Concerning Insurance

Patients who have chiropractic coverage on their insurance are expected to pay their "estimated" co-pay at the time the services are rendered. All co-pay fees quoted are only an "estimate" based upon the information provided to us. It is NOT a guarantee of payment. If you have any questions or concerns about what you particular policy/contract covers, we recommend that you contact your insurance provider for specific policy benefits.

Please remember that your chiropractic coverage is a contract between you (the subscriber) and the insurance company, and NOT between the insurance company and the doctor. As a courtesy to our patients, we are happy to file you chiropractic claims at no charge.

Patients/Responsible parties are required to see that their insurance provider responds within 90 days and the patient is fully responsible for any unpaid balance after 90 days. Your account is subject to a finance charge after for account balances over 90 days.

I assign all insurance benefits to the doctor and understand that any payments received from my insurance company will be credited to my account.

X _____

Responsible Party Signature Date

NON COVERED SERVICES STATEMENT

As your physician, I want to provide you with the best care possible. There are services that I feel are necessary for the treatment of your condition and maintenance of good health that are not covered by your health benefits contract such as, but not limited to, vitamins, food supplements, cervical pillows and/of lumbar supports. You will be expected to pay for those services in full. Let me assure you that I will order only the tests and treatments that I feel are necessary for your treatment and care.

Also, your insurance has limitations to your number of visits per year. If you are treated over the amount that is allowed by your insurance company and they do not pay for additional visits, you will be responsible for the cost of your visit.

If you have any questions about whether or not a particular service is covered by you health benefits contract, someone in our office will be happy to assist you. Thank you for your understanding.

I have read your policy and agree to pay for the services outlined above that are not covered by my contract as indicated by my signature.

X _____

Responsible Party Signature Date

R O S E
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PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRYOUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I,_____, hereby state that by signing this consent, I acknowledge and agree as follows:

1. The Practice's (Rose Chiropractic, Inc., the office of Dr. Timothy Rose, D.C.) Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment for me and also necessary for the Practice to obtain payment for that treatment and to carry out its healthcare operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent and has encouraged me to read the Privacy Notice carefully prior to signing this consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by the practice:
    - A postcard mailed to me at the address provided by me: and
    - Telephoning my home and leaving a message on my answering machine or with the individual answering my phone at the phone number(s) provided by me.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment and as necessary for the Practice to conduct its specific healthcare operations.
5. I understand that I have the right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or healthcare operations. However; the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this consent evidencing my consent to the users and disclosures described to me above and contained in the Privacy Notice, the Practice will not treat me.
9. The Practice may communicate confidential information about me to the following individual(s):

_____

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ X_____
Name of Individual (Printed) Patient/Legal Representative

_____ _____
Date Witness