PENNINGTON CHIROPRACTIC CLINIC

JOHN L. PENNINGTON, D.C.

P.O. Box 1075
ONEONTA, ALABAMA 35121

TELEPHONE (205) 625-3621
FAX (205) 625-3723

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

With my signature below, I give consent for the Pennington Chiropractic Clinic, PC (the Practice) to use and/or disclose information about me (or someone else for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations.

I have reviewed the Privacy Policy of this Practice prior to signing this consent. The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment, or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocations cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent, and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The Practice may communicate confidential information to me, including any invoices for services, at the following address/phone number/fax number/e-mail address:

_____

The Practice may communicate confidential information about me to the following individual(s):_____

_____

_____ _____

Patient/Patient Representative Date

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward 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 well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae 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.

If during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will refer you to the appropriate health care provider who specializes in that area.

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to nervous system. Our only method is specific adjusting to correct vertebral subluxations.

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

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____

CONFIDENTIAL PATIENT INFORMATION

Date:_____ Full Name:_____
Home Phone #_____ Cell #_____ E-mail address:_____
Name of spouse or guardian:_____
Address:_____
Street City State Zip
Marital Status: M S W D Age:_____ Birth Date: _____
Pregnant? Yes No Unsure No. of Children: ____ SS#:_____
Height: _____ Weight: _____ Occupation: _____
Employer: _____ Employer Phone #:_____
Name of Emergency Contact: _____ Phone #: _____

Who may we thank for referring you to us? _____
Chiropractors you have seen in the past:

Name: _____ Date of last visit: _____
Name: _____ Date of last visit: _____

Medical Doctors consulted within the past year:

Name: _____ Condition: _____
Name: _____ Condition: _____

Reason for appoint & related health problems:	Date started or for how long?	Have you had this before	Injury related?
1._____	_____	Yes/No	Yes/No
2._____	_____	Yes/No	Yes/No
3._____	_____	Yes/No	Yes/No

Previous surgeries (Please list all types):
1. Type:_____ Date: _____
2. Type:_____ Date: _____
3. Type:_____ Date: _____

Any implants? (defibrillator, pace maker, etc)?_____

Previous accidents or injuries (especially those that relate to your present problems):

1. Type:_____ Date: _____
2. Type:_____ Date: _____
3. Type:_____ Date: _____

Current Medications:_____
_____

Please circle the following conditions you may have had or have now:

Allergy	Diarrhea	Epilepsy	Headaches	Hepatitis A/B/C
Alcoholism	Eczema	Measles	Stroke	Acid Reflux
Anemia	Gall Bladder	Miscarriage	Ulcers	
Arthritis	Heart Attack	Multiple Sclerosis	Neck Pain	
Migraine	High Blood Pressure	Venereal Disease	Back Pain	
Cancer	Heart Disease	Neuritis	Polio	
Convulsions	Blood Vessel Disease	Nervousness	Pleurisy	
Cold Sores	Low Blood Sugar	Depression	Mumps	
Constipation	Menstrual Cramps	Tuberculosis	Malaria	
Diabetes	Irregular Periods	Pneumonia	Gout	
Sinus	Thyroid Problems	Whooping Cough	HIV	

PAYMENT POLICIES

1. Payment for the first day's service is due at the completion of your office visit. Each visit thereafter, is also due at the time of service.
2. We accept ONLY Blue Cross/Blue Shield insurance as a form of payment. However, we will be glad to fill out your insurance forms for other companies and they may or may not reimburse you.

ASSIGNMENTS AND RELEASE

I authorize release of information to family physicians and employer.

I authorize release of information to insurance companies.

I authorize the taking of photographs and x-rays to be used for treatment purposes.

I acknowledge that I am financially responsible for all services rendered. I also understand that if I terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

I acknowledge that if my insurance company does not pay that I am financially responsible for cost of all services rendered.

Patient's Signature: _____ Date: _____
Guardian's Signature: _____ Date: _____