HIPPA PRIVACY STATEMENT FOR
Edwards Chiropractic & Rehabilitation Center

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION
Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnoses, treatment, and a plan for the future care of treatment. This information often referred to as your health or medical record, serves as, but is not limited to the following.

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal documents describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of date for medical research
- A tool with which we can assess and continually work to improve the care we render and outcome we achieve
- Understanding what is your record and how your health information is used to helps you to:
    - Ensure its accuracy
    - Better understand who, what, when, where & why others may access your health information
    - Make more informed decisions when authorizing disclosures to others

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the healthcare practitioner or facility that complied it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by CFR 164.522
- Obtain a paper copy of notice of information practices upon request
- Inspect and copy your health record as provided in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an account of the disclosures or your health information by alternative means or at alternate locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

OUR RESPONSIBILITIES

This organization is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to all address that you have supplied for us.

We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact our HIPPA Privacy Officer at (412) 446-9100.
If you believe your privacy rights have been violated, you may file a complaint with our HIPPA Privacy Officer. There will be no retalliation for filing a complaint.

THE EDWARDS CHIROPRACTIC AND REHABILITATION CENTER WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling the office.

(Signature)______________________________(Date)______________

(Print Name)____

- OR -

As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

(Signature)______________________________(Date)______________

(Relationship to Patient)_________________________________

Initial/Date ______________ Privacy Officer notified of refusal

______________ Privacy Officer notified of refusal - 2nd Attempt

PATIENT INFORMATION

Date:____________________
Social Security #:____________________
Patient Name:____________________
Last Name

____
First Name Middle Initial
Address:____________________
City:________ State:_____ Zip:________
Sex (Please Circle) Male Female Age:________
Birthdate:____________________
Marital Status (Please Circle) Married Single Divorced Separated Widowed
Occupation:____________________
Patient Employer/School:____________________
Employer/School Address:____________________

____
Employer/School Phone:(___)____________________
Spouse's Name:____________________
Birthdate:____________________
SS#:____________________
Spouse's Employer:____________________
Whom may we thank for referring you?____________________

PHONE NUMBERS

Home Phone:(___)____________________
Cell Phone:(___)____________________
Best time and place to reach you:____________________

IN CASE OF EMERGENCY, CONTACT

Name:____________________
Relationship:____________________
Home Phone:(___)____________________
Work Phone:(___)____________________

INSURANCE

Who is responsible for this account?____________________
Relationship to patient:____________________
Insurance Co.:____________________
Subscriber's Name:____________________
Subscriber's Address:____________________
City:________ State:_____ Zip:________
Subscriber's Birthdate____________________
Subscriber's Employer:____________________
Subscriber's Occupation:____________________
Policy #:____________________
Group #:____________________
Relationship to patient:____________________
Subscriber's SS#:____________________
Is patient covered by additional insurance? Yes No
If so, what type:____________________

ACCIDENT INFORMATION

Is condition due to an accident?(Please Circle)Yes No
Date:____________________
Type of Accident: Auto Work Home Other
To whom have you made a report of your accident?
Auto Insurance Employer Worker Comp Other
Attorney Name (if applicable)

____

ASSIGNMENT OF BENEFITS/RELEASE OF MEDICAL INFORMATION

I hereby assign all medical insurance benefits, including major medical benefits to which I am entitled, to the above-named provider for any and all services furnished to me. I further authorize the provider to release to my insurer or the Health Care Financing Administration, or their respective agents, all information necessary for the determination of benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance, and in the event that I am denied coverage I will make arrangements to pay all bills within 30 days. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment shall be considered as valid as an original.

____________________ ____________________
Signature of Patient/Guardian Date

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare/Medigap benefits be made on my behalf to the above-named provider for any services furnished to me by that provider of service. I authorize any holder of medical information about me to release to the Health Care Financing Administration and/or to the secondary insurer listed above, or their respective agents, any information needed to determine those benefits or the benefits payable for related services. This authorization will remain in effect until revoked by me in writing.

____________________ ____________________
Signature of Patient/Guardian Date

Doctor: Marcus B. Edwards, D.C. Date:__________ Dx:________ ________ ________ ________

Health and Medical Information Release Form

I, ________________________________, give permission to Dr. Marcus B. Edwards, his staff, associates, and employees of Edwards Chiropractic and Rehabilitation Center to share private and medical information with my medical doctor, ________________________________, as well as his or her staff, employees, and associates. Also, my medical doctor, as well as his or her staff, employees, and associates have permission to share personal and medical information with Dr. Marcus B. Edwards and his staff.

Signature: ______________________________

Date: ____________________

Patient Info

Name: ____

Address: ____

City, State, Zip: ____

Phone: ______________________________ Date of Birth: ________________

Medical Doctor Info

Name of Doctor: ____

Address: ____

City, State, Zip: ____

Ph

Below is a list of diseases that 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 chiropractic care.

Check any of the following you have had:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles

- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid

- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

Intake

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE:

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

FEMALES ONLY

When was your last period?

____

Are you Pregnant?

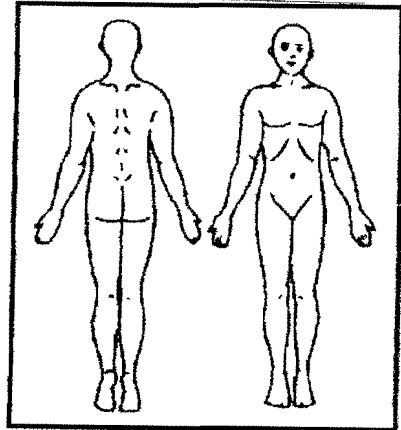
Yes No Not Sure

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke



Please outline on the diagram the area of your discomfort.

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation

- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems

FAMILY HISTORY

The following members have the same problem as you:

- ☐ Mother Child
- ☐ Father Spouse
- ☐ Brother
- ☐ Sister

We Appreciate Your Referrals !!

Past Health History: Please Answer All Questions

Have you ever been involved in a previous accident or major injury? ☐ YES ☐ NO

Have you ever had a previous treatment for neck or back problems other than that already described? ☐ Y ☐ N
Describe (dates & details)

____
____
____

Have you ever had surgery? ☐Y ☐N Describe (dates & details)______________________
____
____

Are You Pregnant? ☐YES ☐NO ☐ NOT SURE LPM:______________________

Any Medical Problems (Diabetes/HBP/Heart/Lungs/Etc.) or other Circumstances? Describe (dates&details)
____
____

Have you ever: (circle and describe below all that apply) Been knocked unconscious Used a cane or crutch Fractured or broken a bone Been Hospitalized Been treated for a spinal disorder Had chiropractic care Have metal in any part of your body.
Describe (dates&details)______________________________
____
____

Did you enjoy good health prior to this accident? ☐ YES ☐ NO explain__________________

List present complaints in order of severity (your primary issue should be listed first)

1.______________________ How or When does it hurt?______________
2.______________________ How or When does it hurt?______________
3.______________________ How or When does it hurt?______________
4.______________________ How or When does it hurt?______________
5.______________________ How or When does it hurt?______________
6.______________________ How or When does it hurt?______________
7.______________________ How or When does it hurt?______________

On a scale of 0 - 10 how do you feel? (0 being near death & 10 being most excellent)? 0 1 2 3 4 5 6 7 8 9 10

What medication are you taking? (list how much & how often)__________________________
____

Please list all known allergies:______________________________
____

please continue onto next page

OUR FINANCIAL POLICY

(PLEASE READ THIS INFORMATION)

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. IF YOU DO NOT HAVE INSURANCE: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payments plans make care an affordable part of your family budget.

2. IF YOU HAVE INSURANCE: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

*You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

*Our fees are considered usual, customary and reasonable by most companies, and therfore are covered up to a maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and care in this area.

*If your carrier has not paid a claim within (60) days of submission, you agre to take an active part in the recovery of your claim. If your insurance carrier has not paid within (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to collect payment in full.

When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

IN WITNESS THEREOF undersigned has here unto set their hands,
this _________ Day of ___________, 2007.

Patients Full name Printed: ____

Patients Signature: ____

Witness to Patients Signature: ____

Columbus Diagnostic Center
2040 Tenth Avenue
Columbus, Georgia 31906
(Phone) 706-322-3000 (Fax) 706-327-9729

I understand that I will be send to Columbus Diagnostic Center for radiological evaluation and reading analysis by a specialist I also understand that the fee for such services will be submitted to my insurance company through Columbus Diagnostic Center. I also understand that this procedure will be a separate expense from Edwards Chiropractic & Rehabilitation Center.

The following signature authorizes the release of medical information and also authorizes the assignment of benefits to:

Columbus Diagnostic Center
2040 Tenth Avenue
Columbus, Georgia 31906
706-322-3000 Fax 706-327-9729

In the event my insurance company or attorney sends payments of services to me, I agree to promptly remit such payment to the Columbus Diagnostic Center.

Patient Signature________________________________

Today's Date________________________________

Witness Signature________________________________

Today's Date________________________________