Name: _____ **Date:** _____

Phone #: _____ **Email:** _____

Date of Birth: _____ **Occupation:** _____

Address: _____

City: _____ **State:** ___ **Zipcode:** _____

How did you hear about us?

Have you ever been to another network spinal chiropractor- if so who?

Have you had any other type of chiropractic care?

Is there any type of chiropractic that you LOVE and any type that you do not like?

What brings you to Connected Spine today?

What would you like to share with me about how you are feeling and how you are functioning?

How do you hope I can best support you?

How would you grade your health? (1-poor, 10-excellent)

physical health 1 2 3 4 5 6 7 8 9 10

mental health 1 2 3 4 5 6 7 8 9 10

emotional health 1 2 3 4 5 6 7 8 9 10

spiritual health 1 2 3 4 5 6 7 8 9 10

What is your background with athletics? How have you moved/used your body in the past and currently. How would you like to use your body in the future?

Have you sustained whiplash injuries and or concussions (sports or non sports related)?

What is your drug history? sustained use of toxic chemicals including alcohol and pharmaceuticals throw our body out of rhythm. and cause inflammation. No shame, no blame, just the facts maam' we are here to create massave coherency and wellness for you.

What have other Doctors told you about your mind-body health? What has been helpful to you and has anything felt harmful for you? Are there any diagnosis' that you accept or reject? (feel free to write on the back)

What other forms of bodywork, healing, medical treatments have you used and what do you like or dislike about them? Basically what works for you?

When you are feeling really great do you prefer to spend time alone, in a small group or at a big event?

When you remember a really happy event in your life, does it come to you
- a feeling, a picture, or a movie?

Is there anything else you feel compelled to share with Dr Suzanne? Hey
you never know. The body and soul don't understand logic, so even if it "doesn't make sense" and you want to add it in here- do it! (well not hereon that back of the page)

Network Spinal Analysis (NSA) Consent Form

It has been explained to my satisfaction, and I understand that the care offered at this office is not a form of, or replacement for, the diagnosis or treatment of any symptom, disease, or malady. Instead, it is a form of wellness care and self education that empowers my connection with my bodymind and develops new strategies for spinal and nervous system integrity and wellness. It develops new capacities in my body for the identification of, spontaneous release of, and redirection of tension, including those that are unique to NSA care. It is common for people receiving NSA care to breathe more deeply and more fully, engaging the spine with their respiration, to spontaneously adapt postures that release or redistribute tension, to bust stress, and to experience more of their inner life energy. I understand it is common to experience a wider range of motion and emotion during care. It is common, as care progresses, to find new options in the body and in life, which often lead to significant life changes.

This form of care is NOT suggested for those individuals who wish to remove a symptom or condition without the occurrence of other fundamental changes in their lives. The care in this office often promotes significant changes in health choices, lifestyle, experience of the bodymind, emotion, and consciousness.

Rather than attempting to simply return me to my previous state minus a symptom, this chiropractor instead chooses to help me achieve new levels of wellness and life potential that I may never have had before.

Although in this office we seek to help you develop new strategies for wellness and spinal and nerve system integrity, as a chiropractor the sole condition of concern is that of the vertebral subluxation. Our insurance carrier requires that the following information be given to you and signed by you prior to commencing care.

In Network Care, we categorize these subluxations into two categories, a structural segmental distortion and a spinal cord/nerve elongation or stretching. Through the gentle force applications at the spine to enhance spinal and nerve system integrity, subluxations are corrected. This is the only condition that we address in our office.

The only condition we offer to diagnose and correct is the vertebral subluxation and loss of spinal and neural integrity in relationship to this. We do not offer to diagnose or treat any other condition, disease, or symptom. If during the course of our spinal assessment/examination we encounter non chiropractic or unusual findings, we will advise you of this. If you desire advise on further diagnosis or treatment of this condition, situation or circumstance, we will recommend that you seek the services of another health care provider whose practice is geared towards such differential diagnosis and treatment.

I have read, or have had read to me, the CONSENT TO RECEIVE NETWORK SPINAL ANALYSIS TM (NSA) CARE and understand that the care in this office is different from what many consumers may expect from chiropractors practicing manipulative therapy. I agree to receive care, which consists of or includes NSA care and wellness education. I understand that I am not passive in this process, but that I am an active participant in my care and in my healing.

_____ _____

SIGNATURE DATE

H.I.P.P.A. Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
(2) We are required to abide by the terms of this Notice currently in effect.
(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care.

Payment: We may need to use or disclose information in your health record to obtain reimbursement for you, from your health-insurance carrier, or from another insurer for our services rendered to you. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system. As a courtesy to our patients, we will provide an itemized bill to you, to 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.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

Change of Ownership: In the event that Connected Spine is sold or merged with another organization, your health information/record will become the property of the new owner.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement official's information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may disclose your health information to law enforcement officials 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. We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board. We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare. 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. We may disclose your health information for military, national security, prisoner and government benefits purposes. Finally, we may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Patient Authorization regarding chiropractic care being provided in an open adjusting environment.
It is the practice of this office to provide chiropractic care in an open adjusting environment. Open adjusting involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in private, confidential setting. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an incidental disclosure of health information. It is our view that the kinds of matters related in an open adjusting environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from Connected Spine or on your relationship with our staff.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

H.I.P.P.A. Notice of Privacy Practices

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's website, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to:

Office Manager - Connected Spine, Mobile Chiropractic, Florida.

I have read a copy of the H.I.P.P.A. Notice of Privacy Practices. By way of my signature, I provide Connected Spine with my authorization and consent to use and disclose my protected healthcare information for the purposes of treatment, payment and healthcare operations as described in the privacy notice.

_____

Patient's Name (print)

_____

Patient's Signature

_____

Date

CANCELLATION POLICY

Occasionally circumstances can arise which might make you unable to attend a scheduled appointment. To prevent any late cancellation charge to you, I ask that you give me 24 hours notice of any cancellation; at which time I will be happy to reschedule your appointment. If less than 24 hours is given you will be charged the full amount of the missed appoinment. I feel that this is the fairest policy for you, for me and for other patients desiring an appointment.

Thank you in advance for your cooperation in this regard.

Sincerely,

Dr. Suzanne McBride, DC

I understand the above cancellation policy:

_____ _____

Name Date