

REGISTRATION

Date _____ Home Phone _____ Work Phone _____ Email _____
 Patient Last Name _____ First Name _____ Initial _____
 Street Address _____
 City _____ State _____ Zip _____
 Sex M F Age _____ Birth date _____ Single Married Widowed Separated Divorced
 Social Security # _____ Driver's License # _____
 Insured Name _____ How and where did you learn about this clinic? _____
 Last Name First Name Initial
 Relationship to Insured Self Spouse Child Other
 Condition/ Illness Related To Illness Employment Auto Other

EMPLOYER	Company Name _____ Occupation _____ Address _____ Phone _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time City _____ State _____ Zip _____ Years Employed _____
SPOUSE (PARENT)	Name _____ Birthdate _____ SSN: _____ Last Name First Name Initial Employer Name _____ Years Employed _____ Address _____ Phone _____ Occupation _____ City _____ State _____ Zip _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID #: _____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID #: _____
MEDICAL AND LEGAL INFORMATION	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? <input type="checkbox"/> Yes <input type="checkbox"/> No Your Initials: _____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No Family Physician _____ Person to contact in emergency (Name and Phone #) _____ Attorney _____ Telephone: _____ Address _____
PATIENT AGREEMENT	LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to <u>Northwest Chiropractic Clinic</u> all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.
	_____ Signature of Insured / Guardian _____ Date

Northwest Chiropractic Clinic

11217 Leopard St. No. 3, Corpus Christi, TX 78410, Ph:361-241-5744, F:361-241-9930

PATIENT HISTORY QUESTIONNAIRE

Name: _____ SSN: _____ Signature: _____ Today's Date: _____

In order for us to better serve you, we need this important confidential questionnaire answered completely by you. If you need any assistance, please do not hesitate to ask our staff for help. Please write clearly for your own health! *Thank you.*

Please list and describe your symptom, problem, condition, diagnosis or other factor that is the reason for your visit to this clinic today: _____

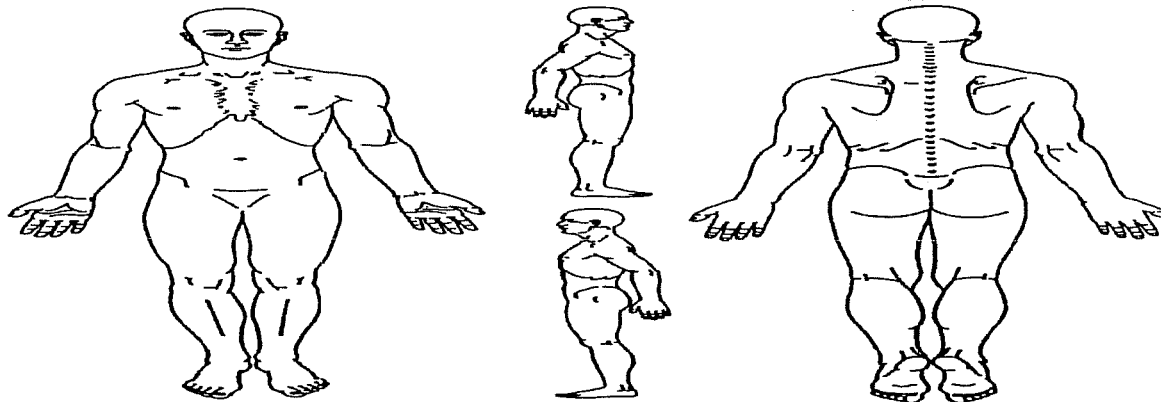
Are your symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? Yes No If you answered yes, please fill out accident specific form, available at the front desk.

Please describe in detail how your present illness / symptoms developed / started (suddenly or gradually) from first sign and / or symptom to the present (including location, quality, severity, duration, timing, context, modifying factors and associated signs and symptoms, etc.)

Describe the quality / character of your symptom (s). Some words often used include burning, tingling, aching, tired, numbness, sharp, dull, stabbing, shooting, radiating, pins and needles, etc. _____

Mark the areas on your body where you feel pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol (s) listed below.

Ache >>>>>	Numbness =====	Pins and Needles ↓↓↓↓↓↓	Burning ××××××
Stabbing ∇∇∇∇∇	Throbbing ~~~~~	Tingling +++++	Sharp ↔↔↔↔↔
Dull 0 0 0 0 0	Soreness ○○○○○	Shooting ⊕ ⊕ ⊕ ⊕	Other



On a pain analog scale of 0 to 10, with 0 being the absence of pain and 10 being significant enough to seek emergency care, which number would describe your pain/discomfort severity, please circle.

What is your pain/discomfort like today? No Pain -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe Pain

What is your least pain/discomfort? No Pain -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe Pain

What is your worst pain/discomfort? No Pain -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe Pain

How much time during an average day are you in pain/discomfort?

Less than 1 hour per day Between 1 and 4 hours per day Almost anytime when not lying down Almost 24 hours per day

Between 4 and 8 hours per day Other _____

What made your current symptoms better or worse? _____

Is your sleep disturbed by these symptoms? YES NO Slightly Moderately Severely

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Have you experienced any restrictions or difficulties in any ACTIVITIES OF DAILY LIVING, SOCIAL and RECREATIONAL ACTIVITIES because of your current condition, please describe in detail (such as bathing, grooming, dressing, eating, walking, stooping, bending, grasping, driving, etc.) YES NO Slightly Moderately Severely

Have you experienced any restrictions or difficulties in performance of your JOB DUTIES at work because of your current condition, please describe in detail YES NO Slightly Moderately Severely

Have you seen a physician or chiropractor outside this clinic for the problem(s) for which you came to this clinic?

YES NO If yes, please list each doctor individually. (for more than one doctor, use additional space to list them)

- If yes, whom did you see? Doctor's Name: _____ Specialty: _____
Address: _____ City _____ State _____ Phone _____
When were you seen? From _____ to _____ Are you still under this doctor's care? Yes No Were
X-ray MRI CAT Scan EMG Bone scan or others _____ taken?
What was diagnosis? _____ What
type of treatment(s) were received? Please list in detail all the treatments you received from this doctor (includes medications, injections, surgeries, physical therapy and others) _____

How much were your symptoms/discomforts improved or helped? Please circle.
No improvement 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 Full improvement

Since your symptoms began, were they improved worsened stayed the same?

Please list your past experiences with illnesses, operations, injuries and treatments);

Illness/injury Date Recurring

Are there any medical events in your family, including diseases which may be hereditary or place you at risk YES No

Have you ever been involved in injuries from following: Yes No If yes, please list all of them with date, type, and legal status
Automobile accident Worker's compensation Personal injuries someone else legally liable for (slip and fall, etc.)
Injury Date Settled Not settled Attorney's Name & Address

Please list all medications (including birth control pills, aspirin, cortisone or vitamins), even if only occasionally, include how often you take the medication, how much you take, and how long you have taken it.

Medication How often How much For how long

Are you allergic to anything (medications, lotion, etc.)? YES NO If yes, to what? _____

Who is filling out this questionnaire? Self Spouse Other _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's Name (print) _____ Signature _____ Date _____

Physician's Signature (upon review) _____ Date _____

Jeffrey L. Shirley DC



**INFORMED CONSENT TO CHIROPRACTIC AND / OR
PHYSICAL MEDICINE SERVICES**

1. I, the undersigned, authorize Dr. Jeffrey L Shirley, and such associates or assistants as he may designate, to perform upon myself the following procedure(s):

- | | |
|---|---|
| <input type="checkbox"/> MANIPULATION | <input type="checkbox"/> PHYSICAL THERAPY |
| <input type="checkbox"/> PHYSICAL EXAMINATION | |
| <input type="checkbox"/> DIGITAL MOTION X-RAY | |

2. I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that the above-named doctor, associates or assistants, may consider necessary or advisable in the course of my health care.

3. The nature and purpose of the procedures, possible alternative mode of treatments, the risks involved, the possible consequences, and the possibility of complications have been explained to me by the above-named doctor.

4. I acknowledge that **NO GUARANTEE OR ASSURANCE** as to the results that may be obtained from the procedure has been given by the above-named doctor.

DO NOT SIGN THIS INFORMED CONSENT UNLESS YOU HAVE READ AND UNDERSTAND ALL PROVISIONS INCLUDED HEREIN.

Date: _____

Signed: _____
Signature of Patient

Time: _____ A.M. P.M.

Signed: _____
Signature of Consenting Party

Witness: _____

Relationship _____

HIPAA

NOTICE OF PRIVACY PRACTICES FOR THE OFFICES OF:

Dr Jeffrey L. Shirley

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.

If you have any questions about this notice, please contact

Dr Jeffrey L. Shirley

Of our office at

11217 Leopard St. #3

Corpus Christi, TX 78410
361 241 5744

<http://www.northwestchiroclinic.com>

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care

outside this office and may require information about you that we have.

For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services

We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that

Authorization, in writing, at any time. If you revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to:

Corpus Christi, TX 78410

in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- b) Is not part of the health information that we keep.
- c) You would not be permitted to inspect and copy.
- d) Is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to:

Corpus Christi, TX 78410

It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or

health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Dr Jeffrey L. Shirley

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact:

Dr Jeffrey L. Shirley

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

Signature: _____

To request restrictions, you may complete and submit a Request For Restricting Uses and Disclosures and Confidential Communications Form Information to:

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the Requests For Restricting Uses and Disclosures and Confidential Communications to:

Dr Jeffrey L. Shirley

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

Dr Jeffrey L. Shirley
11217 Leopard St. #3

361 241 5744

<http://www.northwestchiroclinic.com>

You will not be penalized for filing a complaint.