YOUNGSVILLE CHIROPRACTIC CENTER

700 HWY. 1, Suite 400
Youngsville, NC 27596
(919) 556-2001

Dr. Marion Beaumont

Last Name: ___________________________ First Name: ______________________________Middle Initial: _____

Home Phone: __________________________________ Cell Phone: ______________________________________

Street Address and Number: ____

Mailing Address (If different): ____

City, State and Zip Code: ____

Email Address: ____

Age: _______ Date of Birth: ________________________ Social Security #: _________________________________

Sex: **Male Female** # of Children: ______________ Orientation: **Married Single Widowed Divorced**

Occupation: ___________________________________ Employer: _______________________________________

Spouse's Name: ________________________________ Spouse's Occupation: ______________________________

How were you referred to our office: ____

In case of an emergency, please contact (include phone #): ____

DO YOU HAVE HEALTH INSURANCE YOU WOULD LIKE US TO FILE? **YES / NO**
POLICY HOLDER INFORMATION:

POLICY HOLDER'S NAME: _______________________________ DOB: ___________________________________

EMPLOYER: ____

NAME OF PERSON RESPONSIBLE FOR PAYMENT (if different from applicant): _______________________________

I hereby authorize Dr. Beaumont to examine me, including x-rays if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment, or make payment directly to me.

By signing your name below you certify the accuracy of your medical and/or accident history and further certify that you present to Dr. Beaumont of Youngsville Chiropractic Center for evaluation and treatment of a health related condition as described in your written history and for no other purpose.

____ _______________________________

Signature of patient, or Guardian Authorizing care Date

PATIENT INTAKE FORM

Patient Name: ____________________________ Date: ______________

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. List below what areas you have pain/symptoms:

3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:___________________

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____________
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? ___________

11. How do you think your problem began?

____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

A.)____

What alleviates your problem?

B.)____

16. How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain						

□ □ Angina □ □ Drug/Alcohol Dependance
□ □ Shoulder Pain □ □ Kidney Stones □ □ Allergies
□ □ Elbow/Upper Arm Pain □ □ Kidney Disorders □ □ Depression
□ □ Wrist Pain □ □ Bladder Infection □ □ Systemic Lupus
□ □ Hand Pain □ □ Painful Urination □ □ Epilepsy
□ □ Hip Pain □ □ Loss of Bladder Control □ □ Dermatitis/Eczema/Rash
□ □ Upper Leg Pain □ □ Prostate Problems □ □ HIV/AIDS
□ □ Knee Pain □ □ Abnormal Weight Gain/Loss
□ □ Ankle/Foot Pain □ □ Loss of Appetite **For Females Only**
□ □ Jaw Pain □ □ Abdominal Pain □ □ Birth Control Pills
□ □ Joint Pain/Stiffness □ □ Ulcer □ □ Hormonal Placement
□ □ Arthritis □ □ Hepatitis □ □ Pregnancy
□ □ Rheumatoid Arthritis □ □ Liver/Gall Bladder Disorder
□ □ Cancer □ □ General Fatigue
□ □ Tumor □ □ Muscular Incoordination
□ □ Asthma □ □ Visual Disturbances
□ □ Chronic Sinusitis □ □ Dizziness
□ □ Other:___________________________

20. List all prescription medications you are currently taking: □ See attached list
____

21. List all of the over-the-counter medications you are currently taking:
____

22. List all surgical procedures you have had:
____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why ____

26. Have you ever seen a chiropractor? □ No □ Yes
If yes what were the results? □ **Great** □ **Fair** □ **Mixed** □ **Poor**
How long ago was your last adjusted? ____

27. Have you had significant past trauma? □ No □ Yes

28. What is your: Height___________ **Weight** _____________ **Date of Birth** ___________
Occupation ____

29. Anything else pertinent to your visit today?____

Patient Signature_______________________

YOUNGSVILLE CHIROPRACTIC CENTER

700 Hwy 1., Suite 400, Youngsville, NC 27596
(919)556-2001 * fax (919)556-2207

NOTICE OF PRIVACY PRACTICES Effective Date: April 14, 2003

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.

About Us

In this Notice, we use terms like "we," "us," or "our" refer to YOUNGSVILLE CHIROPRACTIC CENTER, its physicians, employees, staff and other personnel. All of the sites and locations of YOUNGSVILLE CHIROPRACTIC CENTER SERVICES follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes as described in the Notice.

Purpose of this Notice

This Notice describes how we may use and disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practices with respect to your health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information

The following categories describe examples of the way we use and disclose health information.

For Treatment: We may use your health information to provide you with medical treatment or services. For example, your health information will be disclosed to the oncology nurses who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your physician or another healthcare provider to be sure those parties has all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

We may share you health information with pharmaceutical company patient assistance programs and patient support organizations in order to assist you in obtaining payment for your care or payment for certain parts of your care.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities.

We may ask you to sign your name to a sign-in sheet at the registration desk and we may call your name in the waiting room when we call you for your appointment.

We may disclose your health information to a third party that performs services, such as billing and collection, on our behalf. In these cases, we will enter into a written agreement with the third party to ensure they protect the privacy of your health information.

Appointment reminders: We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services.

Treatment Alternatives and Health Related Benefits and Services: We may use your health information to inform you of services or programs that we believe would be beneficial to you. We may call, mail or e-mail you information about these services or goods. For example, we may contact you to make you aware of new products, supply product information, or a new patient assistance program that may be available to you.

Individuals Involved in Your Care or Payment for Your Care: We may release your health information, including information about your condition, to a family member or friend who is involved in your medical care or who helps pay for your care. **If you would like us to refrain from releasing your health information to a family member or friend, please notify** *YOUNGSVILLE CHIROPRACTIC & REHAB CENTER*. We may also disclose your health information to disaster-relief organizations so that your family can be notified about your condition, status and location.

We are also allowed by law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, with limitations, to law enforcement officials for several different purposes:

_ To comply with a court order, warrant, subpoena, summons, or other similar process;
_ To identify or locate a suspect, fugitive, material witness, or missing person;
_ About the victim of a crime, if unable to obtain the victim's agreement;
_ About a death we suspect may have resulted from criminal conduct;
_ About criminal conduct we believe in good faith to have occurred on our premises; and
_ To report a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

_ To prevent or control disease, injury, or disability;
_ To report births or deaths;
_ To report child abuse or neglect;
_ To report adverse events, product defects or problems;
_ To track FDA-regulated products;
_ To notify people and enable product recalls;
_ To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition.

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required by law.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials so they may provide protective services for national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain limited research purposes. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project, assesses a number of specific issues, and determines that appropriate privacy safeguards are in place to allow the use of health information in the research project. We may, however, disclose your health information to people preparing to conduct a research project; for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave the practice.

Other Uses and Disclosures of Your Health Information: Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only with your authorization. If you authorize us to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by the revoked authorization, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment or health care operations. **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. To request restrictions, you must make your request in writing and submit in to *YOUNGSVILLE CHIROPRACTICCENTER 700 Hwy 1., Suite 400 Youngsville, NC 27596.*

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to *YOUNGSVILLE CHIROPRACTIC CENTER. 700 Hwy 1., Suite 400 Youngsville, NC 27596.* We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes or information that is compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to *YOUNGSVILLE CHIROPRACTIC CENTER 700 Hwy 1., Suite 400 Youngsville, NC 27596* . If you request a copy of your health information, we may charge a fee for the costs of copying, mailing, or preparing the requested documents.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request and amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to YOUNGSVILLE CHIROPRACTIC CENTER . *700 Hwy 1. Suite 400 Youngsville, NC 27596.* We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity for file a written statement of disagreement with us.

Right to an Accounting of Disclosures: You have the right to request an accounting of certain disclosures we make of your health information. Please note that certain disclosures, such as those made for treatment, payment or health care operations, need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to *YOUNGSVILLE CHIROPRACTIC CENTER. 700 Hwy 1., Suite 400 Youngsville, NC 27596.* Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact *YOUNGSVILLE CHIROPRACTIC CENTER 700 Hwy 1., Suite 400 Youngsville, NC 27596.*
Right to Complain: If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: *YOUNGSVILLE CHIROPRACTIC CENTER. 700 Hwy 1., Suite 400 Youngsville, NC 27596.* You may also file a complaint with the Secretary of the Department of Health and Human Services. **You will not be retaliated against or penalized for filing a complaint.**

YOUNGSVILLE CHIROPRACTIC CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ________________________________acknowledge that I have received a copy of YOUNGSVILLE CHIROPRACTIC CENTER Notice of Privacy Practices. This Notice describes how YOUNGSVILLE CHIROPRACTIC CENTER may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

____ ______________________________

Signature of Patient, or Personal Representative Date

____

Relationship to Patient

YOUNGSVILLE CHIROPRACTIC CENTER

OFFICE POLICY

OFFICE HOURS: Multiple appointments are arranged for convenience to all patients. Should it be impossible to keep an appointment, we require that you call immediately to reschedule your visits. If you do not notify the office of a cancellation within one hour of your scheduled appointment time, you will be considered a no show and you will be charged an administration fee of $15. After 3 of these, you will be charged $40 and your treatment at this office will be placed on an Administrative hold. It is your obligation to make up any missed appointments within seven days of any cancellation. We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait until the next available appointment. When entering the office, please go directly to the front desk and "sign in". If there are any questions, please ask the front desk assistant.

Test Results and Return Calls: results of any examination, x-rays or lab work will be reported to you as soon as such results are available. Our patients are always informed of all work performed in analysis of their health problems.

Financial Policy: All fees are dependent upon service rendered and are ultimately the responsibility of the patient regardless of whether or not this office accepts insurance assignment for payment of bills. If your insurance is qualified by our insurance coordinator you may be extended the courtesy of assigning insurance benefits directly to the office thereby reducing your out of pocket expenses. This allows you the opportunity to place your family members under chiropractic care.

Patients with no insurance coverage: All payments are expected at time of service or at end of each week. Patient's balance may not exceed $200.00 at any time, or professional services may be terminated.

Any balance past due for 90 days will be sent to a collection agency and a $30.00 collection fee is added onto the balance. Also there is a $20.00 service fee for any returned checks.

Re-evaluation: Should more than a six month time period elapse between office visits, a re-evaluation is necessary prior to reinstating treatment.

Lastly, it is the goal of this office to provide you with the finest quality Chiropractic Care available. If you have any questions with regard to your healthcare, or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for mutual benefit.

I have read the preceding information and understand my responsibility and those of the office.

Date: _____________________ Signature: ______________________________

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700 HWY 1., SUITE 400
YOUNGSVILLE, NC 27596
TELEPHONE: (919)556-2001
FAX: (919)556-2207

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible:_______________________________) by Dr. Marion Beaumont and/or anyone working in this office authorized by Dr. Marion Beaumont.

I further understand that such chiropractic services may be performed by Dr. Marion Beaumont and/or other licensed physicians of Chiropractic who may treat me now or in the near future at this office. I have had an opportunity to discuss with Dr. Marion Beaumont and/or with office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment: including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physicians to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physicians to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

____

Print Patient's Name

____

Print Name of Patient's Representative

____

Signature of Patient/ Signature of Representative

This form should be maintained in the patient's health record.