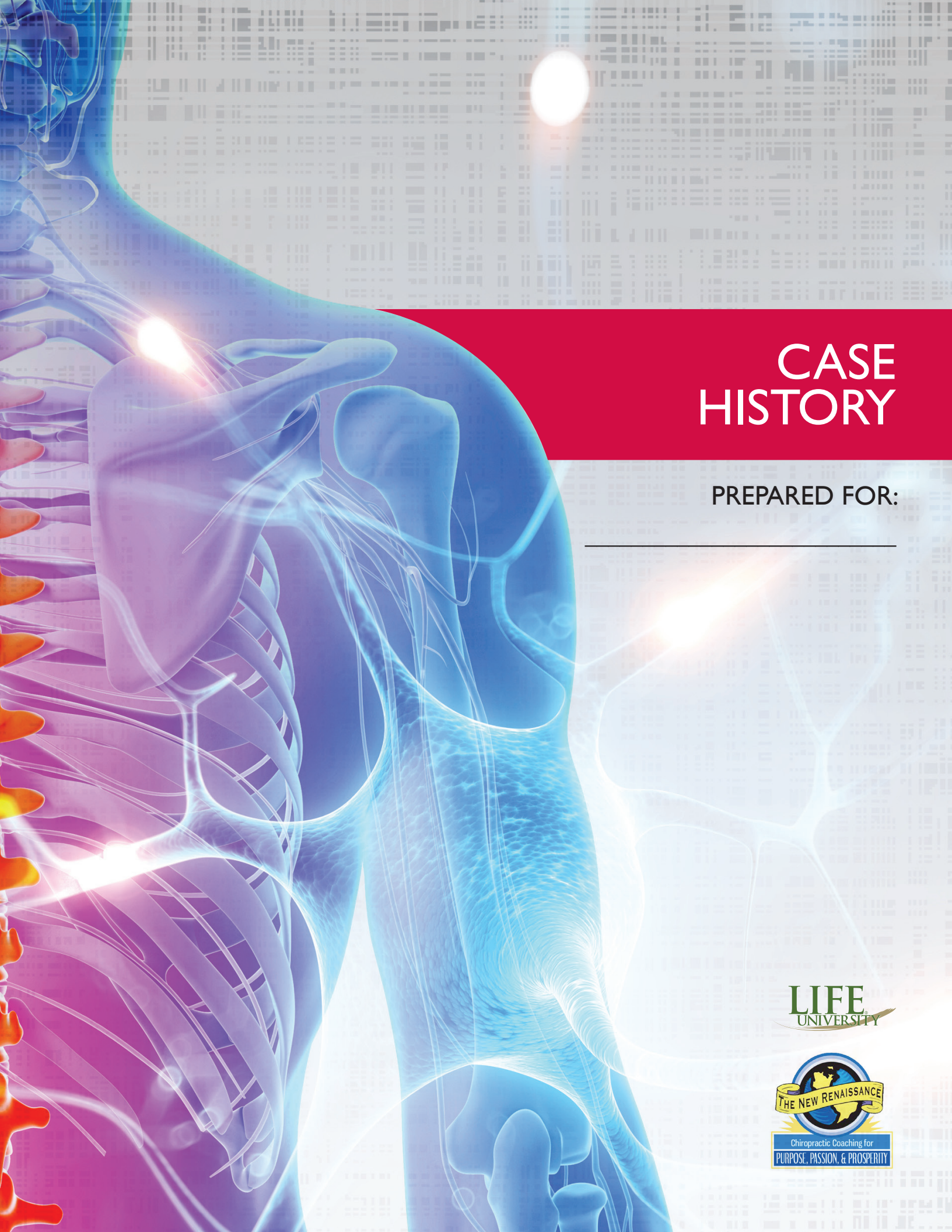

CASE HISTORY

PREPARED FOR:

_____

LIFE UNIVERSITY

THE NEW RENAISSANCE

Chiropractic Coaching for

PURPOSE, PASSION, & PROSPERITY

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that have resulted in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

ABOUT YOUR CARE

Chiropractic provides three types of care. The first is Conditioned Based Care, which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins Corrective Care, which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to Wellness Care. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

LOSS OF WELLNESS (BIRTH-AGE 5)

At birth, when your nerve system is first damaged, your wellness begins to decrease and the journey to ill health starts.

Yes	No		Patient Comment (if answer is yes)	Chiropractor's Comments
		1. Pregnancy		
		Did your mother:		
☐	☐	Smoke or drink alcohol?		
☐	☐	Have a proper diet?		
☐	☐	Exercise through her pregnancy?		
☐	☐	Experience any falls and injuries during pregnancy?		
☐	☐	Experience any physical and/or mental abuse?		
		2. Birth Process		
☐	☐	Was the delivery long?		
☐	☐	Was the delivery difficult?		
☐	☐	Forceps?		
☐	☐	Caesarean?		
☐	☐	Breach/cephalic?		
☐	☐	Home Birth?		
☐	☐	Hospital Birth?		
☐	☐	Mother given drugs during delivery?		
☐	☐	Was labor induced?		
		3. Growth and Development		
☐	☐	Were you taught how to care for your spine?		
☐	☐	Did you roll out of bed?		
☐	☐	Were you a headbanger or rocker?		
☐	☐	Were you breastfed?		
☐	☐	Childhood sicknesses?		
☐	☐	Accidents?		
☐	☐	Surgery?		
☐	☐	Drugs?		
☐	☐	Did you fall while learning to walk?		
☐	☐	Were you picked on by siblings?		
☐	☐	Child abuse?		
☐	☐	Spanking (how?)		
☐	☐	Pulled ear/chin?		
☐	☐	Other		
☐	☐	Chair pulled out when sat down?		
☐	☐	Did you fall down stairs?		
☐	☐	Were you yanked by your arm?		
☐	☐	Did you have other traumas? What? When?		

LOSS OF WHOLE BODY HEALTH (AGE 5-PRESENT)

As layers of damage increased, you probably began to experience symptoms and random bouts of sickness.

Yes	No		Patient Comment (if answer is yes)	Chiropractor's Comments
☐	☐	Were you taught proper body movement and care?		
☐	☐	Did/do you smoke?		
☐	☐	Did/do you drink any alcohol?		
☐	☐	Diet (Do you eat healthy foods?)		
☐	☐	Have you ever been in accidents?		
☐	☐	Have you had surgery and organs removed/replaced?		
☐	☐	Drugs? (Prescriptive or non-prescriptive)		
☐	☐	Teeth problems?		
☐	☐	Eye problems?		
☐	☐	Hearing problems?		
☐	☐	Exercise regularly?		
☐	☐	Sleeping habits (nightmares?)		
☐	☐	Did/do you have occupational stress?		
☐	☐	Physical stress?		
☐	☐	Mental stress?		
☐	☐	Hobbies/Sports injuries?		
☐	☐	Other traumas or problems?		

SYMPTOMS & ILL HEALTH (PRESENT STATE OF ILL HEALTH)

Years of untreated damage showed up as acute or chronic symptoms.

Other Symptoms:

- ☐ Headaches
- ☐ Neck Pain
- ☐ Sleeping Problems
- ☐ Back Pain
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Face Flushed
- ☐ Neck Stiff
- ☐ Pins & Needles in Legs
- ☐ Pins & Needles in Arms
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Shortness of Breath
- ☐ Fatigue
- ☐ Depression
- ☐ Lights Bother Eyes
- ☐ Loss of Memory
- ☐ Ears Ring
- ☐ Fever
- ☐ Fainting
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Diarrhea
- ☐ Feet Cold
- ☐ Hands Cold
- ☐ Stomach Upset
- ☐ Constipation
- ☐ Cold Sweats
- ☐ Loss of Balance
- ☐ Buzzing in Ears

PRESENT COMPLAINT

Major complaint: _____

Pain or problem started when: _____

Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent Is condition getting progressively worse? ☐ Yes ☐ No

What activities aggravate your condition/pain? _____

Is condition worse during certain times of the day? ☐ Yes ☐ No If so when? _____

Is this condition interfering with (circle those that apply): ☐ Work? ☐ Sleep? ☐ Routine? ☐ Other: _____

Other doctors seen for this condition: _____

Any home remedies? _____

SYMPTOMS & ILL HEALTH (CONT'D)

Have you been under drug and medical care? ☐ Yes ☐ No

If yes, please explain: _____

What medications are you taking? _____ How long? _____

Have you had surgery? ☐ Yes ☐ No

For what? _____

When? _____

What side effects (if any) did you experience from drugs and surgery?

FAMILY HISTORY

Father's side

- ☐ Heart Disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Other: _____

Mother's side

- ☐ Heart Disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Other: _____

PATIENT INFORMATION

Name: _____ Social Security #: _____ Date: _____

Gender: ☐ Male ☐ Female Date of birth: _____ (Age: _____) If you were referred, by whom? _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Marital status: ☐S ☐M ☐D ☐W Spouse's Name and Occupation: _____

Number of Children and Ages: _____

Have you ever recieved Chiropractic care? ☐ Yes ☐ No

Have you ever been in an accident? ☐ Yes ☐ No ☐ Work ☐ Auto ☐ Other: _____

Nature of accident: _____ When: _____

Did you require post-accident hospitalization? ☐ Yes ☐ No

Did you lose days at work as a result? ☐ Yes ☐ No How many? _____

Is insurance involved? ☐ Yes ☐ No Which company? _____

Attorney's name ☐ n/a _____ Claim #: _____

Comments (office use only):

Beth Anne Flack, DC, PC

4246 Washington Rd.
Suite 6
Evans, GA 30809

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for who I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by working associated with or serving as back up for the doctor of chiropractic named above, including those working at the office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other 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, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on facts then known, is in my best interests.

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

TO BE COMPLETED BY PATIENT OR PATIENTS REPRESENTATIVE, IF NECESSARY, E.G. PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

_____

PRINT PATIENT'S NAME SIGNATURE DATE

_____

REPRESENTATIVE RELATIONSHIP DATE

WITNESS TO PATIENT'S SIGNATURE: _____

DATE: _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION FOR THE OFFICE OF BETH ANNE FLACK, DC, PC

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information to any outside marketing organization. We must abide by the terms of this notice while it is in effect, but we reserve the right to change the terms of our privacy notices. If we make a change, it will apply for all of your health information in our files, and we will notify you in writing if/when you come in for treatment. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

All correspondence should be addressed to:
Attn: HIPAA Compliance
Officer Beth Anne Flack, DC, PC
4246 Washington Rd. Ste. 6
Evans, GA 30809

USES AND DISCLOSURES

Here are some examples of how we might have to use or disclose your health care information:

1. We may have to disclose your health information to a massage therapist, another health care provider, or a hospital, etc., if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your examination and treatment records and your billing records to another party (i.e. your insurance company or your attorney), if they are potentially responsible for the payment of your services.
3. We may need to use any information in your file for quality control purposes or any other administrative purposes to run our practices.
4. We may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, birthday greetings, newsletter, treatment alternatives, or other health related information that might be of interest to you (i.e. test results). 164.520(b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine or it will be mailed.

You have the right to refuse to give us authorization to contact you regarding your case at this office. If you do not give this authorization, it will not affect the treatment we provide you or the methods we use to obtain reimbursement for your care including billing you by mail or collecting proceedings. You may inspect or copy the information that we use to contact you regarding your care at any time (i.e. appointment reminders, care alternatives, etc.).

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. Any restriction should be requested in writing. We are not required to honor these requests. However, if we agree with your restrictions, the restriction is binding on us.

PERMITTED USES & DISCLOSURES WITHOUT YOUR CONSENT AUTHORIZATION

Under federal law, we are also permitted or required to use or disclose your health information without your consent of authorization in the following circumstances.

1. We are providing health care services to you based on the orders (referral) of another health care provider.
2. We provide health care services to you in an emergency we are unable to obtain your consent after attempting to do so.
3. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

REVOKING YOUR AUTHORIZATION

You may revoke your authorization to us at any time in writing. There are two circumstances under which we will not be able to honor your revocation requests:
164.508(b)(5)(I) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

CONFIDENTIAL COMMUNICATION

We will attempt to accommodate any reasonable written request regarding how/where (i.e. mailing address or contact numbers) you would like to receive information remains in our files. We require a written request to amend your records that include a valid reason to the change. We have the right to refuse your request.

AMENDING YOUR HEALTH INFORMATION

You have the right to request that we amend your health information for seven years from the date that the record was created as long as the information remains in our files. We require a written request to amend your records that include a valid reason to the change. We have the right to refuse your request.

INSPECTING/COPYING YOUR HEALTH INFORMATION

You have the right to inspect the health information contained in your files while in our office and/or have a copy made for you. Your health information is available up to seven years from the date the record was created or as long as the information remains in our files. Your request must be in writing to *inspect the* records and/or have them copied. There will be a charge of $.50 per page. Original x-ray films are the property of this office because we are required by law to keep it in our records. Original films can be *released on referral to another physician.*

ACCOUNTING OF DISCLOSURES OF YOUR RECORDS

You have the right to request an accounting of any disclosures (not listed below) made of your health information for six years to the date of your request. The request must be in writing. *The accounting will* exclude the following disclosures:

-required for you treatment, to obtain payment for services, to run our practice, and/or made to you.
-necessary maintain a directory of the individuals in our facility or to individuals involved with your care
-for national security, intelligence purposes, or law enforcement officers.
-that were made prior to the effective date of the HIPAA privacy law (April 14, 2003)

We will provide the first accounting within 12 month period without any charge, but any additional requests will be charged a fee. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

RE-DISCLOSURE

We cannot control the actions of others to whom we have released your *information for treatment.* Information that we use or disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by the federal privacy rules.

COMPLAINTS

You may complain to us or the Secretary for Health and Human Services if you feel that we have violated *your privacy rights or respect* you rights to file a complaint and will not take any action against you if you file a complaint. Written comments should be addressed to our office address or Secretary for Health & Human Services, 200 Independence Ave, S.W., Room 509F, HHH B, Washington, D.C. 20201.

This notice will expire six years after the date upon which the record was created.

Beth Anne Flack, D.C. PC
Doctor of Chiropractic

ACKNOWLEDGEMENT OF RECEIVING PRIVACY POLICY AND AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMTION

By signing below, I acknowledge that I have received a copy of the Privacy Policy of Dr. Beth Anne Flack, D.C., P.C. I further acknowledge that I was encouraged to read the policy carefully and given the opportunity to ask questions about the policy. I authorize Beth Anne Flack, D.C., P.C. to use and disclose my protected health information for the purposes of treatment, payment and healthcare operations, as described in the Privacy Policy. This notice is effective as of the date on which it is signed and this notice will expire six years after the date it was created.

Signature of Patient or Authorized Representative Today's Date

Print Name of Patient or Authorized Representative Print relationship to Patient, if applicable

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 towards 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.

Adjustment: An adjustment is the specific application of force 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 vertebra 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 it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter a non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. 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.

Signature _____ Date _____

EMERGENCY CONTACT SHEET

Patient's Name_____

1st
Contact_____

Address_____
_____

Phone (_____) _____-_____

2nd
Contact_____

Address_____
_____

Phone (_____) _____-_____

Flack Family Chiropractic

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____

    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event: _____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____

Name of the Individual Giving this Authorization Date of birth

_____ _____

Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524

Flack Family Chiropractic
4246 Washington Rd. Suite 6, Evans, GA 30809
(706) 305-3241

We are dedicated to providing you with the best possible care and service and regard your understanding of our financial policy as an essential element of your care and treatment. Our office does not file insurance, however we would be happy to provide you with a copy of the bill showing your diagnosis and payment so you may ask your insurance company for reimbursement. If you have any questions, please feel free to call and discuss them with our billing department.

___**All fees are due at the time of service** unless prior arrangements have been made. For your convenience, we accept cash, personal checks, Visa, Mastercard, and American Express. *Failure to pay at the visit will result in a $5.00 service charge.* As a courtesy, we will accept personal checks as payment, however, checks returned by your bank will incur a returned check fee and may result in a complaint being filed with the Columbia County Sheriff's Department/Magistrate Court of Columbia County.

___We ask that you give at least 24 hour notice should you need to cancel an appointment**. A $45 fee will be billed to you directly for appointments that are not cancelled prior to 24 hours.** Unfortunately, this has been made necessary by the increasing numbers of patients not keeping their appointments. This prevents us from seeing other patients that are in need of medical attention. This fee is NOT covered by your insurance and must be paid prior to your next appointment.

___**All accounts are payable in full within 60 days.** Please contact our billing department if you have extenuating circumstances. Please be aware that we use the services of an outside collection agency for past due accounts. In the event that your account is turned over to collections, you will be responsible for all reasonable collection and court costs.

___Unpaid balances are billed monthly. We use computer billing and are aware that sometimes billing errors do occur. Please call if you have a question about you bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying your bill or are unable to pay on the day that you are seen, please explain the situation to us. Satisfactory arrangements can almost always be made. We strive to remain flexible and understanding of individual circumstances; we are certain to have suggestions; and we will do our best to help.

I have read and understand the financial policy of Flack Family Chiropractic and agree to be bound by the terms.

Signature of Responsible Party / Patient Printed Name Date