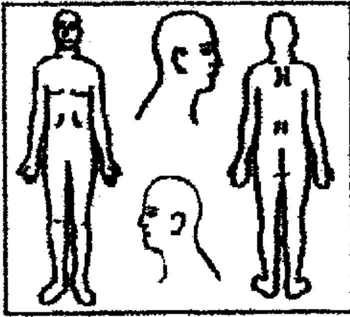
Patient: Last Name_______________ First Name _________ Middle ____ Birthday _________ Date _________
Address _____________________________ City _________ State _____ Zip ______ Home Phone____________
Cell Phone _______________ Work Phone _______________ SS# _______________ Driver lic. # ___________
Referred By ______________ [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Children Ages ___________
Occupation _____________ Employer ____________ Address _____________________ Insurance Co _________
ID# ______________ Are You the card holder [ ], or your [ ] Spouse? **SPOUSE:** ____________ SS# ___________
Occupation ________________ Employer _______________ Work Address ___________________________
Phone__________ Emergency Contact: ________________ Phone # __________ Relationship _____________

What is your **Major Complaint?** ____
CIRCLE ALL THAT APPLY: ____
WHEN did this Start? ______________________ **HOW** did this start? ____________________ Have you had this or a similar condition in the past? _______ **When**? _____________________ Have you seen another Physician for today's Problem? **Yes / No** If so, **Who**? _______________ **When**? ____________________
What makes it **BETTER**? Heat / Cold / Movement / Sitting / Laying / Other ___________________
What makes it **WORSE**? Heat / Cold / Movement / Sitting / Laying / Other ____________________
Does the Pain get **BETTER / WORSE** as the day goes on? Is the Pain? Sharp / Dull / Burning / Radiating down Arm/Leg / Constant / Comes & Goes / Getting Progressively Worse
Other Complaints? ____

Pain Rating: ***LEAST - TO - WORST***
1 2 3 4 5 6 7 8 9 10

MARK the area of PAIN



PLEASE CHECK ALL THAT APPLY

__ Neck Problem	__ Sore Muscles	__ Allergies
__ Headaches	__ Muscle Cramps	__ Hay Fever
__ Shoulder Problems	__ Walking Problems	__ Asthma
__ Arm Problems	__ Tiredness/Fatigue	__ Eczema
__ Numbness Arm/Hand	__ Weak Muscles	__ Shingles
__ Pain Btw Shoulders	__ Dizziness	__ Ulcers
__ Low Back Problem	__ Nausea	__ Poor Digestion
__ Leg Problems	__ Forgetfulness	__ Diarrhea
__ Numbness legs	__ Depression	__ Constipation
__ Stiff/painful Joints	__ Ear Pain/Infections	__ Kidney Infection
__ Restricts ADL's	__ Frequent Colds	__ BP High / Low
__ Restricts Reg Exercise	__ Menstrual Cramps	

This is a ***new / old*** illness. Treated before ***yes / no***
If yes, what was done? ______________________
Name of Doctor __________________________
Have you ever been hospitalized? _____________
List Surgeries ___________________________
Have you had Chiropractic care before ***yes / no***
Name of Doctor ____________ Date __________
Last time you have had spinal xrays ____________
Medications you now take ____________________

From Birth to Present list by Date & Describe
Car Accidents: 1 - ______________________________
2 - ______________________________
3 - ______________________________
Falls/Injuries: ______________________________
*(including sports)*______________________________
____
Other: ______________________________
____

C-ROM:		1 ______	2 ______	3 ______
Flexion	60	______	______	______
Extension	50	______	______	______
R Lat Flex	40	______	______	______
L Lat Flex	40	______	______	______
R Rotation	80	______	______	______
L Rotation	80	______	______	______

pH ____/_____, _____/_____

L-ROM:		1 ______	2 ______	3 ______
Flexion	90	______	______	______
Extension	30	______	______	______
R Lat Flex	20	______	______	______
L Lat Flex	20	______	______	______
R Rotation	30	______	______	______
L Rotation	30	______	______	______

B/P = L___/___ R ___/___ Ht: _______
P/R = L________ R ________ Wt: _______

DATE:	1 _________	2 _________	3 _________	
TEST	L / R	L / R	L / R	
C.Com flex/ext	___/___	___/___	___/___	
F. Compression	___/___	___/___	___/___	1) Oppo
C. Distraction	___/___	___/___	___/___	R / L
Shoulder Dep	___/___	___/___	___/___	Psoas
Valsalva C/T/L	___/___	___/___	___/___	R / L
Dermo C5 – T1	___/___	___/___	___/___	
MT C5,6,7,8,T1	___/___	___/___	___/___	
Kemps	___/___	___/___	___/___	2) Oppo
Dermo L2 –S1	___/___	___/___	___/___	R / L
Lasegue's	___/___	___/___	___/___	Psoas
Braggards	___/___	___/___	___/___	R / L
Fabere Patrick	___/___	___/___	___/___	
Beckterews	___/___	___/___	___/___	3) Oppo
Toe/Heel	___/___	___/___	___/___	R /L
Fajersteins	___/___	___/___	___/___	Psoas
Bakody's Sign	___/___	___/___	___/___	R / L
__________	___/___	___/___	___/___	

Review of Systems

Patient Name: ____________________ Patient File #: __________ Today's Date: ____/____/____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional:
- None
- Chills
- Daytime Drowsiness
- Fatigue
- Fever
- Night Sweats
- Weight Gain
- Weight Loss

Eyes/Vision:
- None
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Eye Pain
- Field Cuts
- Glaucoma
- Itching *(around the eyes)*
- Photophobia
- Tearing
- Wears Glasses or Contacts

Ears, Nose and Throat:
- None
- Bleeding
- Dental Implants
- Dentures
- Difficulty Swallowing
- Discharge
- Dizziness
- Ear Drainage
- Ear Infection*(s)*
- Ear Pain
- Fainting
- Headaches
- Head Injury *(history of)*
- Hearing Loss
- Hoarseness
- Loss of Smell
- Nasal Congestion
- Nose Bleeds
- Post Nasal Drip
- Rhinorrhea *(runny nose)*
- Sinus Infections
- Snoring
- Sore Throats
- Tinnitus *(ringing in the ears)*
- TMJ Disorder

Cardiovascular:
- None
- Angina *(chest pain or discomfort)*
- Chest Pain
- Claudication *(leg pain or achiness)*
- Heart Murmur
- Heart Problems
- Orthopnea *(difficulty breathing while lying)*
- Palpitations *(irregular or forceful heart beat)*
- Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
- Shortness of Breath
- Swelling of Leg*(s)*
- Ulcers
- Varicose Veins

Gastrointestinal:
- None
- Abdominal Pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice *(yellowing of the skin)*
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber *(quality)*
- Abnormal Stool Color
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood

Respiration:
- None
- Asthma
- Coughing up blood
- Shortness of Breath
- Sputum Production
- Wheezing

Endocrine:
- None
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Frequent Urination
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

Skin:
- None
- Changes in Nail Texture
- Changes in Skin Color
- Hair Growth
- Hair Loss
- Hives
- Itching
- Paresthesia (numbness, prickling, or tingling)
- Rash
- History of Skin Disorders
- Skin Lesions or Ulcers
- Varicosities

Nervous System:
- None
- Dizziness
- Facial Weakness
- Headaches
- Limb Weakness
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors
- Unsteadiness of Gait

Allergy:
- None
- Anaphylaxis *(history of)*
- Food Intolerance
- Itching
- Nasal Congestion
- Sneezing

Hematology:
- None
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusion*(s)*
- Bruises easily
- Fatigue
- Lymph Node Swelling

Psychological:
- None
- Anhedonia *(inability to experience joy or enjoy life)*
- Anxiety
- Appetite Changes
- Behavioral Change*(s)*
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Insomnia
- Memory Loss
- Mood Change*(s)*

Female:
- None
- Birth Control Therapy
- Breast Lumps / Pain
- Burning Urination
- Cramps
- Frequent Urination
- Hormone Therapy
- Irregular Menstruation
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

Male:
- None
- Burning Urination
- Erectile Dysfunction
- Frequent Urination
- Hesitancy or Dribbling
- Prostate Problems
- Urine Retention

Patient Signature: ______________________________

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient: ____________________ ________

Doctor Signature Date

Chemical Balance Form

The purpose of this NUTRITIONAL QUESTIONNAIRE is to help determine your alkaline reserve status (your pH), because healing happens within the body in a certain chemical range. Anything outside of that range can slow down or stop the healing process.

The Stiff Test – The Fist Test – The Sniff Test

1. Are you stiff and sore when you get up in the morning? ❐Yes ❐No
2. Do you feel good in the morning but have pain and tightness as the day goes on? ❐Yes ❐No
3. Are you generally restless and don't sleep well? ❐Yes ❐No
4. First thing in the AM, squeeze really hard to make a fist. Does it hurt/or is hard? ❐Yes ❐No
5. Do you notice the smell of ammonia in your urine? ❐Yes ❐No
6. Is your urine foamy? ❐Yes ❐No
7. Do you have a burning sensation when you urinate? ❐Yes ❐No

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How quickly you get well is determined by the chemical balance in your body. Chemical balance is determined, in large, by what you eat. Please indicate the amounts and frequencies you partake in the following:

YOU MUST BE BRUTALLY HONEST!

Amount of:	**Per Day**	**Per Week**
1. Coffee (caffeinated/decaffeinated)	_____ cups	_____ cups
2. Tea (herbal & regular)	_____ cups	_____ cups
3. Sugar, sweets, desserts, candy, and artificial sweeteners	_____ times	_____ times
4. Salt, salty snacks, chips, etc.	_____ servings	_____ servings
5. Do you add salt to food at meal time?	❐Yes ❐No	❐Occasionally
6. Red meat (beef, pork, bacon, ham, etc.)	_____ times	_____ times
7. Chicken/Fish	_____ times	_____ times
8. Dairy (milk, cheese, ice cream, etc.)	_____ glasses/times	_____ glasses/times
9. Water	_____ glasses	_____ glasses
10. Fresh fruits	_____ pieces	_____ pieces
11. Fresh vegetables (non-canned)	_____ servings	_____ servings
12. Alcoholic beverages	_____ servings	_____ servings
13. Soft drinks (caffeinated/decaffeinated)	_____ servings	_____ servings
14. Smoking	_____ packs	_____ packs

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________________ **Date** ____________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score ____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ **Date** __________

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Wellness Care Form

Bio-Energetic Synchronization Technique is ultimately about wellness care. Granted, many of us will have symptoms or issues that need to be dealt with immediately, but eventually, as those become resolved, we have the ability to create the life and health picture of our dreams.

In order for our office to assist you in achieving your wellness status, help us define what that would look like for you. List 3 goals you would love to achieve regarding your perfect health and your ideal life. (Use your imagination and assume that anything would be possible for you.)

1. ______________________________

2. ______________________________

3. ______________________________

On a scale of 1 – 10, with 1 being "not much" and 10 being "almost anything," demonstrate what you would be willing to change, let go of, shift, start, or stop in order to accomplish these goals.

---

1 2 3 4 5 6 7 8 9 10

- Does it *feel* possible to personally achieve these goals?

❐Yes ❐No

- Would you be willing to investigate any *subconscious* interference that may be getting in your way? (You won't need to reveal any personal information in order to do so.)

❐Yes ❐No

- Have you ever had someone demonstrate (via muscle testing) how your *subconscious* beliefs can sabotage your ability to obtain your goals? The Law of Attraction operates through your *subconscious* mind. What your *subconscious* believes is what will manifest in your life.

❐Yes ❐No

- Did you know there is a procedure you can easily learn that would enable you (working with a partner) to remove the *subconscious* interference that stops you from achieving your goals?

❐Yes ❐No

- Would you like to learn how? It's called BEST RELEASE.

❐Yes ❐No

"With your commitment and this technique, we can make a difference."

FINANCIAL POLICY

We are committed to providing you with the best possible care. We will gladly discuss your proposed treatment and answer any questions you may have.

INSURANCE:

We must emphasize that as health care providers our relationship is with **you**, not your insurance company. While filing your insurance is a courtesy we extend to our patients, all charges are ultimately your responsibility from the time services are rendered. **All deductible** amounts are due at the time of the **first visit**. Your co-payment amounts are due at the time services are rendered! Any amount billed to your insurance company not paid within **45 days** will be billed to you and due in 10 days!

WORKERS COMPENSATION:

Worker's compensation pays in full for chiropractic care in most cases. We require that the patient furnish us with **written approval** from the employer at the time of the **first visit**. If authorization cannot be obtained from the employer's insurance within 48 hours, all charges will be due immediately!

PERSONAL INJURY:

Please present your **Auto Insurance** and a copy of the **Accident Report** during your **first visit.** If an attorney is handling your case please provide this office with that information. If there is **med pay** (medical payments) on your auto policy we will bill the **Automobile Policy First! You Are Ultimately Responsible** for your bill, if there is no med pay on your automobile insurance policy, as a courtesy we will wait for payment until your case is settled. You will be required to make a **$15.00 co-payment** at the time of each visit and we will bill the at fault automobile insurance company **Second**. If you have health insurance in addition to automobile insurance we will bill your health Last! Should you **terminate care**, for any reason, **all charges** will be **due in Full, Immediately!**

MEDICARE:

We are participating in Medicare and accept Medicare on assignment. Medicare does not pay for examinations or radiographs in a chiropractic office. This fee will be your responsibility during your **initial visit.** Medicare co-pays range from **$5-$10.00** due at the time services are rendered.

COLLECTION POLICY:

Should your account ever have to be turned over to collection, all costs incurred will be billed to the account. This includes any attorney fees and all court costs.

All balances are due in full regardless of insurance status, at the time you terminate treatment for any reason. If your insurance pays us we will reimburse you for any amount overpaid this office. You will be Billed a **$35.00** office visit, if **24 hours notice** is not given prior to missing an appointment.

I understand and agree that, (regardless of my insurance status), **I AM ULTIMATELY RESPONSIBLE** for the balances on my account. I have read, or have had read to me, all the information in this agreement.

Signature____________________________________ **Date**__________________

INFORMED CONSENT

A patient in coming to the Chiropractor gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give a chiropractic adjustment or health care if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures what ever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the chiropractor. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The chiropractor provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

Patient Signature____________________________________ Date_________________

CONSENT FOR TREATMENT

I the undersigned, a patient in this office hereby authorize Dr. Joel L. Dinoff DC and whomever he may designate as his assistant(s) to administer treatment as is necessary.
I also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and agent. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittance for the conveyance of credit to my account. However, I clearly understand and accept that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient Signature____________________________________ Date _______________

Release of Information, Assignment of Benefits And Reimbursement Policy Form

Name of Patient: ______________________________

Patient ID#: ______________________________

Authorization for Release of Information
I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

Authorization of Assignment
I authorize payment of medical benefits to ______________________________ for services rendered to me.

Reimbursement Policy
We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payments and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

____
Patient Printed Name

____
Patient Signature

____
Date

Call 1-800-270-7044 or visit www.TargetCoding.com for mor e information.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

I ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ] Individual refused to sign

[ ] Communications barriers prohibited obtaining the acknowledgement

[ ] An emergency situation prevented us from obtaining acknowledgement

[ ] Other (Please Specify)

____

____

____

NOTICE OF PRIVACY PRACTICES

Purpose: This notice of Privacy Practices "Notice" presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this notice to each patient beginning no later than the date of our first service to the patient, including service delivered electronically, after April 14, 2003. We must make a good faith attempt to obtain written acknowledgment of receipt of the Notice from the patient. We must also have the Notice in our office in a clear prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice and on the website. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with above instructions. Thereafter, we must distribute the Notice to each patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

Dr. Dinoff is required to provide you with this Notice pursuant to the privacy regulations implementing the Health Insurance Portability and Accountability Act of 1966 ("HIPPA") ("Privacy Rules")

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

Uses and Disclosures

We may use or disclose your protected information without your written consent, written authorization or oral agreement for the following purposes:
Treatment: *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.
Payment: *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.
Health Care Operations: *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

We may use or disclose your protected health information without your written consent, written authorization or oral agreement under the following circumstances:
If we provide services to you while you are an inmate.
If we provide services to you in an emergency treatment situation.
If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.
If there are substantial barriers to communication and we determine in the exercise of our professional judgment, that you intend for us to treat you.

If we need to notify, or assist in the notification of, a family member, personal representative or another person responsible for your care of your location general condition or death.
If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.
If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.
If we are required by law to disclose your health information to the Food and Drug Administration.
If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness.
If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect or domestic violence.
If we are required to disclose your health information to a health oversight agency for oversight activities required by law.
If we are required to disclose your health information in response to a court order or a subpoena.
If we are required to disclose your health information to a law enforcement official.
If we are required to disclose your health information to a coroner, medical examiner or funeral director.
For Research Purposes.
If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.
If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illness.

WITH THE EXCEPTION OF THE ABOVED CIRCUMSTANCES, ANY USE OR DISCLOSURE OF YORU HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION.

YOUR RIGHTS

RIGHT TO REQUEST RESTRICTIONS. You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official.
RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS. You have right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our Privacy Official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.
RIGHT TO INSPECT AND/OR COPY. You have the right to inspect and/or copy certain health information for as long that information remains in your record. Your

request to inspect and/or copy your health information must be made in writing to our Privacy Official.

RIGHT TO AMEND. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the request amend.

RIGHT TO RECEIVE AN ACCOUNTING. You have the right to receive and accounting of our disclosures of your health information made 6 years prior to the date of your request. We will provide you with the first accounting in any 12 month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to out Privacy Official. The accounting will not include the following disclosures:

Disclosures made to carry out treatment, payment and healthcare operations;
Disclosures made to you;
Disclosures made in our facility directory;
Disclosures made to individuals involved with your care;
Disclosures made for national security or intelligence purposes;
Disclosures made to correctional institutions or law enforcement officials; and
Disclosures made prior to the compliance date of the HIPPA Privacy Rule.

RIGHT TO RECEIVE NOTICE. Your have the right to receive a paper copy of this notice, upon request.

OUR DUTIES

We are required by law to maintain the privacy of protected health information and to provide you with notice of legal duties and privacy practices with respect to your protected health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this notice, we will notify you in writing and provide you with a paper copy of the new notice upon request.

COMPLAINTS

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address that follows. We will not take any action against you for filing a complaint.

HOW TO CONTACT US

If you would like further information about our privacy practices, please contact:

Dr. Joel L. Dinoff
2745 Sandy Plains Road, Suite 134
Marietta, Georgia 30066
770-509-2554

Effective Date: January 1, 2003

PERSONAL INJURY/WORKER'S COMP QUESTIONAIRE

Name__________________________ Date of Accident________________ Time__________

Please Attach Accident Report & Fill Out Completely!!!

Where did the accident happen?____

Describe the accident in your own word:

____

____

____

Was your vehicle? Standing Still __Yes __No Speeding Up __Yes __No Slowing Down __Yes __No

Traveling at _____MPH What was your position in the car? ___Driver ___Passenger

If passenger, where were you sitting in? __Front __Right Rear __Left Rear

Were you wearing a seat belt/lap belt? __Yes __No Did you receive a bruise from the belt? __Yes __No

Did your vehicle strike another vehicle? __Yes __No Was your vehicle struck by another vehicle? __Yes __No

Was the impact from? __The Front __The Right Side __The Left Side __The Rear

Were both hands on the steering wheel? __Yes __No Was your foot on the brake? __Yes __No

Were you surprised by the impact? __Yes __No Were you braced for the impact? __Yes __No

At the time of impact where were you looking? __Straight Ahead __Right __Left __Other ______________

What direction was your trunk facing? __Straight Ahead __Left __Right

Where in the car were you after the accident?________________________________

In relation to the back of your head, was your headrest set: __Low __Medium __High

Did you strike anything in the vehicle at the time of impact? __Yes __No If Yes specify:
__Steering Wheel __Dashboard __Windshield __Side Door __Arm Rest __Side Window __Other

Please state part of body: __Chest __Chin __Knee __Shoulder __Hand __Head __Other

Immediately following the accident, Did you feel pain? __Yes __No >>>>> How did you feel?

____

What bleeding cuts did you sustain during this accident?______________________________

What bruises did you sustain during this accident?___________________________________

Did you loose consciousness (black out)? __Yes __No How long? ________________

Did you become? ___CONFUSED DISORIENTED ___LIGHT HEADED ___DIZZY ___NAUSEATED
___BLURED VISION ___IN A DAZE ___RING/BUZZ IN EARS

If you went to the hospital, when? ________. At time of accident? __Yes __No Next Day __Yes __No

How did you get to the hospital? Ambulance __Yes __No Private transportation? __Yes __No

Name of Hospital? ____________________ Attended by Dr.________________________________

Were you x-rayed? __Yes __No What was the Diagnosis? _________________________

Were you admitted to hospital? __Yes __No How long did you stay? ______________________________

Is your pain Constant? __ Yes __No Is the pain On and Off? __Yes __ No

Sharp? __ Yes __ No Dull? __ Yes __ No Other ____

Is pain made Worse when? Arising from a chair? __Yes __No Is it made Worse by? Straining __Yes __No

Coughing? __Yes __No Sneezing? __Yes __No Straining moving your bowels? __Yes __No

Do you have any Numbness or Tingling in Your? Arms __Yes __No Hands __Yes __No

Fingers __Yes __No Legs __Yes __No Feet __Yes __No Toes __Yes __No

Do you have Cramps In? Legs __Yes __No Arms __Yes __No

What is your most comfortable position? Sitting __Yes __No Lying on your: __Right side __Left side

__Back __Stomach __Standing Other ____

Is it difficult to move around in bed? __Yes __No Has your sleep been interrupted? __Yes __No Does Stretching or

Twisting worsen the Pain? __Yes __No Do you feel better moving around? __Yes __No Or resting? __Yes __No

Does a Brace Help, if tried? __Yes __No Have your Bowel Habits changed? __Yes __No

Have you lost any time from work because of this accident? __Yes __No

Give Dates of Time lost: *From*______________ *To*________________
Totally Disabled: *From*______________ *To*________________
Partially Disabled: *From*______________ *To*________________

Are you Currently Suffering from any of the following *(Please Circle all that apply)*:

Restlessness	Irritable	Difficulty Concentrating	Difficulty with memory
Sleeplessness	Forgetfulness	Reduced Tolerance to Heat	Reduced Tolerance to Alcohol

How far is the top of the headrest or seat back from the top of you head?*(Approximately)*: _______inches above or below

List the year, make and model of the vehicle you were in: Year______ Make_____________ Model______________

What is the estimated cost of damage to the vehicle *You were in?* $____

Which of the following car parts broke during the accident? __Windshield __Front Seat __Right side window

__Left side window __Steering Wheel Other ____

List the year, make and model of the other vehicle? Year______ Make___________ Model_________________

If the other vehicle was moving at the time of the collision, was it: __Slowing Down __Speeding Up __Standing Still

Moving at a steady speed of about ________

DR. JOEL L. DINOFF
Dinoff Family Chiropractic Health Wellness & Weight Loss Center
2745 Sandy Plains Rd
Ste 134
Marietta, GA 30066
770.509.2554

To: ______________________________
____
____
____

Re: Medical Reports and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me BOTH BY REASON OF THIS ACCIDENT and BY REASON OF ANY OTHER BILLS THAT ARE DUE HIS OFFICE and TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGEMENT OR VERDICK AS MAY BE NECESSARY TO ADEQUATELY PROTECT SAID DOCTOR. And I hereby further give lien on my case to said doctor against any and all proceeds of any settlement, judgement or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Dated: ________________ Patient's Signature: ______________________________

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor above named.

Dated: ________________ Attorney's Signature: ______________________________

MEDICAL PROVIDER'S CONTRACT

This is an agreement between the undersigned patient, hereafter called "patient", and provider, hereafter called "provider", for full and complete payment of the provider's medical services and expense by the patient from the proceeds of any insurance settlement, judgement at trial, or recovery from any other means or sources.

In consideration the provider hereby agrees to provide the patient or patient's attorney with reports of care and condition including a narrative report upon request.

In further consideration the provider agrees upon reasonable request to meet with the patient or the patient's attorney to discuss the treatment of the patient.

This is an obligation coupled with an interest. It is NOT an agreement for payment based upon the outcome of any claim or litigation.

Patient agrees to pay provider regardless of the outcome of any case, claim or litigation in which the provider's reports, notes care and treatment plan is used.

Following the outcome of the claim, case or litigation, if collection becomes necessary, patient will then become liable for interest at the highest current rate and provider's attorney fees and expenses for collection.

A copy of this contract is to be sent to the patient's attorney with a request the attorney follow these directions in making payment from any recovery to the undersigned provider.

This agreement shall follow the patient and binds all attorneys or firms handling the patient's case.

Patient directs his attorney to withhold payment of the provider's total bill for services/expenses for any settlement to recovery from whatever source and to make payment immediately to the provider.

This direction is irrevocable and these directions must be followed by patient's attorney regardless of patient's wishes at a later date.

This agreement does not waive any right of the provider or preclude the provider from any reasonable actions to collect.

Read, understood, agreed and signed by these parties on this date ____/_____/________.

______________________________	______________________________
Provider	Patient
______________________________	______________________________
Date	ATTORNEY'S SIGNATURE

Attorney: Please date, sign and return one copy of this agreement to the doctor's office. Medical reports will be forwarded upon its receipt. You may keep one copy for your records.