

New Life Chiropractic Center
3451 Cobb Parkway Ste.6, Acworth, GA 30101
(678) 574-5678 Fax: (678) 574-5605

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to New Life Chiropractic Center (NLCC) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to NLCC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If NLCC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to NLCC to use my name on a welcome board, referral board, and birthday board.
- I give permission to NLCC to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to NLCC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give NLCC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving NLCC permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at New Life Chiropractic Center plus 7 years or until revoked by me.

(over)

Name _____ Home Phone _____
Address _____ Work Phone _____
City, State, Zip _____ E-mail Address _____
Birth date _____ Age _____ SS# _____
Occupation _____ Employer _____
Marital Status: M W Sep. D Sin. Spouse Name _____ No. of Children _____

1. Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend/Family Member Name _____

Telephone Call Yellow Pages Sign Website Presentation E-mail

2. Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? _____ Never

3. When was your last complete spinal examination including x-rays? _____ Never

4. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem? YES NO _____

5. Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? YES NO

6. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? YES NO

7. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture? Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

8. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days. Low - 1 2 3 4 5 6 7 8 9 10 - High

9. Please list any health symptoms or health complaints you are experiencing.

1. _____ 2. _____ 3. _____

10. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking?

11. Auto and work-related injuries can cause serious spinal problems. Is this visit related to an accident or injury? YES NO Date of Incident _____

12. Spinal health is especially important during pregnancy. Is there any chance that you are pregnant? YES NO

13. Have you ever been diagnosed with cancer? Type _____ Year _____

14. If the doctor feels that chiropractic will help you, are you willing to follow his/her recommendations? YES NO

15. Would you like to receive our weekly health and wellness newsletter via e-mail?
 YES NO

The above information is true and accurate to the best of my knowledge.

Patient Signature _____ Date _____