WELCOME BACK

PATIENT INFORMATION UPDATE FORM

Potomac Family & Sports CHIROPRACTIC CENTER ©
21351 Gentry Dr., Suite 125 • Sterling, Va 20166
703-406-8686 • www.dr-alex.com

Name _____ Date _____

Address _____ Name of Insurance Company

City _____ State _____ Zip _____ _____

Home# _____ Work# _____ ID number

Cell# _____ Fax# _____ _____

E-mail address _____ Group number

Emergency Contact Name _____ _____

Emergency Contact Phone# _____ Provider Phone# _____

In order to better serve you, we need information regarding your current health condition

Have you had any falls, accidents or surgery since your last visit? ❑ Yes ❑ No

If yes, please explain: _____

What are your symptoms? _____

Have you been treated for a similar problem before? ❑ Yes ❑ No

If yes, please explain: _____

When did symptoms appear? _____

What have you done at home to treat any pain? _____

Have you seen another Doctor since your last visit? _____

What medications are you taking?

❑ Muscle relaxant ❑ Insulin ❑ Pain Killer

❑ Birth Control ❑ Stimulants ❑ Anti Depressants

Other: _____

What vitamin supplements are you taking? _____

What exercise program are you using? _____

Do you smoke? ❑ Yes ❑ No Amount per week _____

Do you drink alcoholic beverages? ❑ Yes ❑ No Amount per week _____

Do you use any back or arch supports, heel lifts, orthotics or any braces of any kind? ❑ Yes ❑ No

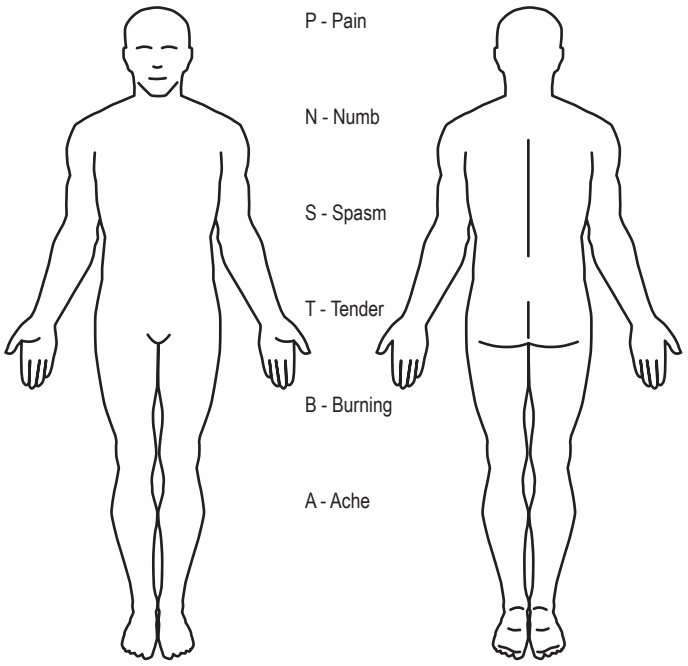
PATIENT IS RESPONSIBLE FOR OBTAINING ALL REFERRALS

I HEARBY AUTHORIZE ASSIGNMENT OF BENEFITS TO BE PAID TO POTOMAC FAMILY & SPORTS CHIROPRACTIC CENTER. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A POTOCOPY OF THIS AGREEMENT IS TO BE CONSIDERED VALID AS ORGINAL. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGMENTS HAVE BEEN MADE IN ADVANCE. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL FOR ALL COINSURANCE AND DEDUCTIBLE COSTS AS WELL AS ANY DOCTOR'S SERVICES WHICH ARE DETERMINED TO BE NON-COVERED OR DENIED. I AUTHORIZE MY PHYSICIAN TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY BILL.

Patient's Signature: _____

Guardian or Spouse's Signature: _____

Symptom Localization



least 1 2 3 4 5 6 7 8 9 worst

MUSCULO SKELETAL SYSTEM
- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain Arm problems
- ❑ Swollen joints
- ❑ Painful Joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder problems

GASTRO-INTESTIONAL SYSTEM
- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM
- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscle jerking
- ❑ Convulsions
- ❑ Depression
- ❑ Insomnia

CARDIO-VASCULAR RESPITORY
- ❑ Chest pain
- ❑ Pain over the heart
- ❑ Difficulty breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung Problems
- ❑ Varicose veins

EYE, EAR, NOSE AND THROAT
- ❑ Eye strain
- ❑ Eye Inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose Bleeding
- ❑ Nose discharge
- ❑ Difficulty breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw pain

GENITO-URINARY SYSTEM
- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE
- ❑ Lumps on or in the breast
- ❑ Breast pain
- ❑ Vaginal pain
- ❑ Vaginal bleeding
- ❑ Vaginal discharge

ARE YOU PREGNANT ❑ Yes ❑ No

Potomac Family & Sports CHIROPRACTIC CENTER ©

SUMMARY

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____
3. If this is a recurrence, when was the first time you noticed this problem? _____
   How did it originally occur? _____
   Has it become worse recently? Yes _____ No _____ Same _____ Better _____ Gradually Worse _____
   If yes, when and how? _____
4. How frequent is the condition? Constant _____ Daily _____ Intermittent _____ Night Only _____
   How long does it last? All Day _____ Few Hours _____ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____. If yes, describe: _____
   Are there other unrelated health problems? Yes _____ No _____.
   If yes, describe _____
6. Describe the pain: Sharp _____ Dull _____ Numbness _____ Tingling _____ Aching _____ Burning _____
   Stabbing _____ Other _____
7. Is there anything you can do to relieve the problem? Yes _____ No _____.
   If yes, describe _____
   If no, what have you tried to do that has not helped? _____
   _____
8. What makes the problem worse? Standing _____ Sitting _____ Lying _____ Bending _____ Lifting _____
   Twisting _____ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____
   _____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____
11. Remarks: _____
    _____
    _____

NO SYMPTOMS — EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

Doctor's Signature _____ Date _____

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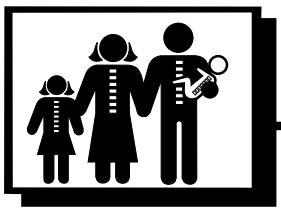

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CHIROPRACTIC CENTER

ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY

To Whom It May Concern:

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to POTOMAC FAMILY & SPORTS CHIROPRACTIC CENTER, INC. such sums as may be due and owing to this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, no-fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me or from a settlement, judgment or verdict on my behalf as may be necessary to adequately protect this office. I hereby further give a lien to said office against any and all insurance benefits names herein, and any and all proceeds to the settlement, judgment or verdict which may be paid as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this office for their services, refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor again such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further, I authorize this office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due this office for their services. I further understand and agree that this Assignment, Lien and Authorization do not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned office be given power of attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

I have read and understand the above policy _____ Date _____
signature

_____
please print name here

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Potomac Family & Sports CHIROPRACTIC CENTER

January 1, 2014

Dear Patients,

Due to an increased number of missed appointments and last minute cancellations Dr. Alex McMinn of Potomac Family & Sports Chiropractic, Inc., now finds it necessary to institute a new policy.

Effective January 1, 2014, patients who fail to provide a 24-hour notice of cancellation for a scheduled appointment, continue to have chronic tardiness, or who fail to show up for scheduled appointments, will be charged a fee of $50.00.

Implementation of this policy will benefit all of our patients who require quality attention, and will also allow us to schedule appropriately and effectively. We try hard not to over schedule so that you have time for a quality chiropractic adjustment. Patients who do not respect or value their scheduled time result in lost time for someone who really needs our services, and causes us to sometimes run behind. This is the reason for the new policy.

We do understand that situations arise, however please be mindful and respectful of other patient's time and the doctor's time. Your understanding in this matter is greatly appreciated.

In Health,

Dr. Alex McMinn

I have read and understand the above policy _____ Date _____
signature

_____
please print name here

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Potomac Family & Sports CHIROPRACTIC CENTER

STATEMENT OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the Commonwealth of Virginia. This includes issues relating to your treatment, payment, and our chiropractic care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION

We will only request personal information needed to provide our standard of quality chiropractic care, implement payment activities, conduct normal chiropractic practice operations, and comply with the law. This may include your name, address, telephone number, Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

PATIENT RIGHTS

You have the right to request copies of your health care information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at POTOMAC FAMILY & SPORTS CHIROPRACTIC CENTER, INC. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

I have read and understand the above policy _____ Date _____

signature

_____

please print name here

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