Friends & Family
HEALTH CENTERS

Application for Care

Whom may we thank for referring you to this office?

_____

FOR OFFICE USE ONLY

DX CODES

Today's Date: _____-_____-_____

Please fill out these forms in their entirety so the doctors can deliver the highest level of care and get you functioning at your highest level of health.

PATIENT DEMOGRAPHICS

Name: _____

Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____

Mobile Phone: _____

Do you have Insurance: ☐ Yes ☐ No Driver's License No.: _____

Employer: _____ Occupation: _____

Spouse's Name _____

No. of Children: _____ Ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

Are you pregnant? ☐ Yes ☐ No ☐ Trying ☐ N/A If so, how far along are you? _____ weeks

Date of your last menstruation: _____-_____-_____ Are you breastfeeding? ☐ Yes ☐ No

If you would like to receive text/email reminders for your appointment(s), please list your mobile phone number with your service provider, and/ or your email:

_____ _____ OR _____
Mobile Phone Service Provider Email

HEALTHCARE

Please list the names of your current healthcare professionals:

Primary Care MD: _____ Pediatrician: _____

OBGYN: _____ Massage Therapist: _____

Specialist: _____

Have you been adjusted by a chiropractor before? ☐ Yes ☐ No

If so, how did they adjust you: ☐ Manual ☐ Instrument ☐ Muscle Work

Was it satisfactory? ☐ Yes ☐ No

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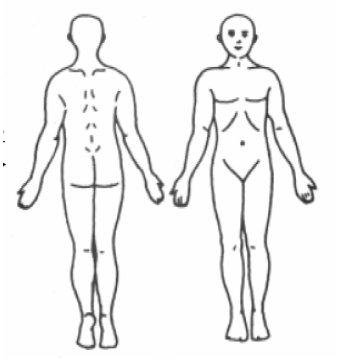
Please identify the condition(s) that brought you into this office:

Mark the areas on the diagram with the following letters to describe your symptoms:



1 Complaint: _____

How did it happen? _____

Initial occurrence date: ____ / ____ / _____ Most recent occurrence: ____ / ____ / _____

How frequently does this happen? _____

On a scale of 0 to 10, with 0 being no pain and 10 being the worst pain, rate your complaint by circling one in each section:

At its worst 0 1 2 3 4 5 6 7 8 9 10 At its best 0 1 2 3 4 5 6 7 8 9 10

Average 0 1 2 3 4 5 6 7 8 9 10 In the past 0 1 2 3 4 5 6 7 8 9 10

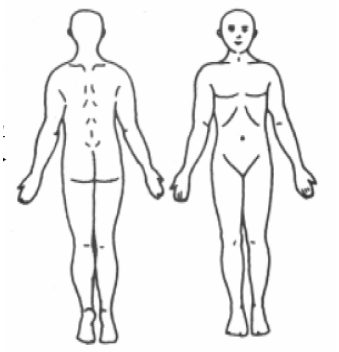
When is this problem at its worst? ___ AM ___ Mid-day ___PM ___Late PM ___Constant ___Random

How long does it last? ___Constant ___ On & off throughout day ___ Comes & goes throughout week ___Random

Have you been treated for this condition in the past? No ___ Yes ___ If yes, when:_____

By whom?_____ For how long? _____ What were the results? _____

How does this condition affect your activity level? _____



2 Complaint: _____

How did it happen? _____

Initial occurrence date: ____ / ____ / _____ Most recent occurrence: ____ / ____ / _____

How frequently does this happen? _____

On a scale of 0 to 10, with 0 being no pain and 10 being the worst pain, rate your complaint by circling one in each section:

At its worst 0 1 2 3 4 5 6 7 8 9 10 At its best 0 1 2 3 4 5 6 7 8 9 10

Average 0 1 2 3 4 5 6 7 8 9 10 In the past 0 1 2 3 4 5 6 7 8 9 10

When is this problem at its worst? ___ AM ___ Mid-day ___PM ___Late PM ___Constant ___Random

How long does it last? ___constant ___ on & off throughout day ___ comes & goes throughout week

Have you been treated for this condition in the past? No ___ Yes ___ If yes, when:_____

By whom?_____ For how long? _____

What were the results? _____

How does this condition affect your activity level? _____

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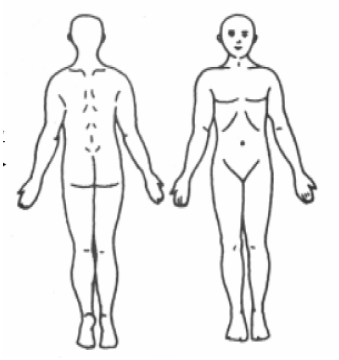
Please identify the condition(s) that brought you into this office:

Mark the areas on the diagram with the following letters to describe your symptoms:



3 Complaint: _____

How did it happen? _____

Initial occurrence date: ____ / ____ / _____ Most recent occurrence: ____ / ____ / _____

How frequently does this happen? _____

On a scale of 0 to 10, with 0 being no pain and 10 being the worst pain, rate your complaint by circling one in each section:

At its worst 0 1 2 3 4 5 6 7 8 9 10 At its best 0 1 2 3 4 5 6 7 8 9 10

Average 0 1 2 3 4 5 6 7 8 9 10 In the past 0 1 2 3 4 5 6 7 8 9 10

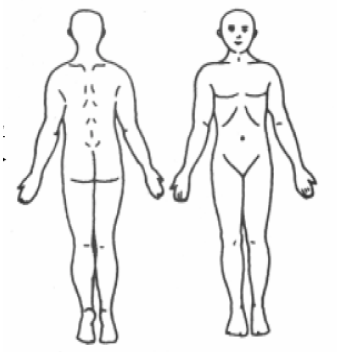
When is this problem at its worst? ___ AM ___ Mid-day ___PM ___Late PM ___Constant ___Random

How long does it last? ___Constant ___ On & off throughout day ___ Comes & goes throughout week ___Random

Have you been treated for this condition in the past? No ___ Yes ___ If yes, when:_____

By whom?_____ For how long? _____ What were the results? _____

How does this condition affect your activity level? _____



4 Complaint: _____

How did it happen? _____

Initial occurrence date: ____ / ____ / _____ Most recent occurrence: ____ / ____ / _____

How frequently does this happen? _____

On a scale of 0 to 10, with 0 being no pain and 10 being the worst pain, rate your complaint by circling one in each section:

At its worst 0 1 2 3 4 5 6 7 8 9 10 At its best 0 1 2 3 4 5 6 7 8 9 10

Average 0 1 2 3 4 5 6 7 8 9 10 In the past 0 1 2 3 4 5 6 7 8 9 10

When is this problem at its worst? ___ AM ___ Mid-day ___PM ___Late PM ___Constant ___Random

How long does it last? ___constant ___ on & off throughout day ___ comes & goes throughout week

Have you been treated for this condition in the past? No ___ Yes ___ If yes, when:_____

By whom?_____ For how long? _____

What were the results? _____

How does this condition affect your activity level? _____

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On a scale of 0-5, 0 being the worst and 5 being the best:

How healthy do you consider yourself?	0	1	2	3	4	5
How healthy do you consider your family?	0	1	2	3	4	5
How many hours are you sitting per day?	0	1	2	3	4	5+
How many hours of sleep do you get on average?	2	3	4	5	6	7+

Do you get adequate amounts of sleep? ☐ Yes ☐ No Is it restful? ☐ Yes ☐ No

Do you sleep through the night? ☐ Yes ☐ No Difficulty falling asleep? ☐ Yes ☐ No ☐ Sometimes

How many of the following products do you use a week:

Diet beverages/Soda?	0	1	2	3	4	5+
Zero calorie/sugar free beverages?	0	1	2	3	4	5+
Artificial Sweeteners?	0	1	2	3	4	5+
Coffee?	0	1	2	3	4	5+
Energy products?	0	1	2	3	4	5+

Do you get tired/ sleepy after a meal? ☐ Yes ☐ No

Do you get sensitive or angry if a meal is missed? ☐ Yes ☐ No

Circle the meals you eat: Breakfast Lunch Dinner Snacks

Do you eat snacks in between meals? ☐ Yes ☐ No

How many times a day do you eat?	0	1	2	3	4	5+
How many bowel movements do you have a day?	0	1	2	3	4	5+

Are they firm or loose? _____ Dark or light? _____

Are you a vegetarian? ☐ Yes ☐ No

How many days a week do you exercise?	0	1	2	3	4	5+

For how long? _____

What type of activity? _____

Do you use artificial sweeteners? ☐ Yes ☐ No

How much water do you drink per day? _____

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Current medications?

1) _____ 2) _____ 3) _____

Current supplements?

1) _____ 2) _____ 3) _____

3 healthiest foods you eat? 1) _____ 2) _____ 3) _____

3 unhealthiest foods you eat? 1) _____ 2) _____ 3) _____

Initial all of the following with: P for in the Past C for Currently have N for Never have had

____ Broken Bone
____ Fracture
____ Osteo Arthritis
____ Depression
____ High Blood Pressure
____ Diabetes 1 or 2
____ Surgery
____ Cold hands/feet

____ Indigestion/Heart burn
____ Gas
____ Bloating
____ Dislocations
____ Diarrhea
____ Constipation
____ IBS/Celliac
____ Allergies

____ Disability
____ Tumors
____ Cancer
____ Cerebral/Vascular
____ Dizziness
____ PMS
____ Forgetfulness
____ Headache
____ Migraine

____ Breathing Issues
____ Rheumatoid Arthritis
____ Heart Attack
____ Fatigue
____ Anxiety/Stress
____ Gluten Sensitivity
____ Dairy Sensitivity
____ Auto Immune Disease
____ Other

SOCIAL HISTORY

1. SMOKING: FREQ: ☐ Never ☐ Past ☐ Daily ☐ Weekends ☐ Occasionally
☐ cigars ☐ pipe ☐ cigarette ☐ vaporizer

2. ALCOHOL: FREQ: ☐ Never ☐ Past ☐ Daily ☐ Weekends ☐ Occasionally

3. REC. DRUGS: FREQ: ☐ Never ☐ Past ☐ Daily ☐ Weekends ☐ Occasionally

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes

If yes, whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ son(s) ☐ daughter(s)

Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

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I hereby authorize payment to be made directly to Homewood Friends and Family Healthcare, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Homewood Friends & Family Healthcare for any and all services I receive at this office.

_____

Patient's Name

_____ _____/ _____/ _____

Patient or Authorized Person's Signature Date Completed

_____ _____/ _____/ _____

Doctor's Signature Date Form Reviewed

If you would like to receive text/email reminders for your appointment(s), please list your mobile phone number with your service provider, and/ or your email:

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HEALTH CENTERS

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be able to obtain it. It will prevent any confusion or disappointment. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Health is a state of optimal physical, mental and social well being, not merely the absence of disease or infirmity. Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximal health. If during the course of a chiropractic spinal evaluation, we encounter 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.

Print Name

I understand the intent of Chiropractic care, based on the above, & consent to an examination, including X-rays if necessary.

_____ _____ — _____ — _____

Signature Date

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FINANCIAL POLICY

We are committed to providing you with the best health care possible. We have established our financial policies to achieve this goal. You will be expected to pay for your health care at the time the service is rendered unless other arrangements are made in advance.

Health Insurance: We accept Blue Cross Blue Shield insurance. On your first visit, we will check your benefits and collect payment based on the information given on the Blue Cross Blue Shield portal. Insurance claims are filed on a bi-weekly basis. Once remittance files are received from Blue Cross Blue Shield, your ledger will be updated. If your ledger shows a credit, we will reimburse you the difference between what you paid and the patient responsibility stated in the remittance form. If your ledger has a balance, you will be responsible for it and required to pay for it without dispute. If during your care your insurance information changes, it is your responsibility to update your records with our office.

If you are not a BCBS insured, it is your responsibility to collect these benefits. We will provide you with a statement or "Superbill" at your request, which contains all the information necessary for your insurance company to reimburse you.

Cash Patients: All fees are payable at the time services are rendered.

Methods of Payment: For your convenience we accept Cash or Credit Cards (Visa, MasterCard, AMEX, Discover) for your initial visit. If a payment plan is chosen for future care, this is handled by auto collection through your card on file with our office. We do not accept checks for your initial first two visits. All checks returned as insufficient funds will incur a $45 returned check fee.

We make the payment process as simple and smooth as possible, so you will have an enjoyable visit in our office.

I have read and understand the above policies.

_____ _____ — _____ — _____

Patient Signature (Parent or Legal Guardian) Date

_____

Print Name

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HEALTH CENTERS

PATIENT ATTENDANCE POLICY AGREEMENT

Homewood Friends and Family Chiropractic strives to provide each patient with the highest quality of care while attempting to accommodate your schedule. Therefore, we provide reserved time slots for each patient in order to minimize waiting times and assure continuity of your personal treatment. Appointments can be scheduled by phone, email, or in person at the office. We ask that all patients arrive 5 minutes before your scheduled time to empty your pockets and warm up your spine. Your consistent attendance of the planned treatment care plan is paramount to your health.

Cancellations, along with patient no-shows, decrease our ability to accommodate the scheduling needs of other patients. We ask for your full cooperation with the following policy:

- If you are unable to keep a scheduled appointment, we request that you notify our office 24 hours in advance of your scheduled appointment time. If someone is not available to take your call, please leave a voicemail or email frontdesk@homewoodfreindsandfamily.com.

- All chiropractic no call, no shows will be documented in our records. If you accumulate 2 no call no shows, an office visit will be deducted from your careplan on each no call, no show thereafter.

- All muscular therapy no call, no shows will be charged a fee of half the price of the scheduled muscular therapy session.

- All nutritional no call, no shows will be assessed a $25 fee.

We believe that this policy is necessary for the benefits of all patients, so that we can continue to provide the highest quality treatment and service to every patient.

All Homewood Friends and Family Staff and patients appreciate your cooperation with this policy.

_____ _____ — _____ — _____

Patient Acknowledgement/Signature Date

Friends & Family
HEALTH CENTERS

PRIVACY NOTICE ACKNOWLEDGEMENT

We are concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the uses and limitation of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I, _____ acknowledge that I have received a copy of Homewood Friends and Family Healthcare's Notice of Privacy Practices for Protected Health Information.

_____ _____ — _____ — _____

Patient Signature (Parent or Legal Guardian) Date

_____ _____

Personal Representative Printed Personal Representative Signature

Description of personal representative's authority to act for the patient:

_____

_____

_____

_____

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HEALTH CENTERS

NOTICE OF PRIVACY FOR PROTECTED HEALTH INFORMATION

This notice Describes how Chiropractic and Medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Use and Disclosures

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

1. An HF&FH staff member may have to disclose your health information, including all of your clinical records, to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health.

2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.

3. An HF&FH staff member may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.

4. An HF&FH staff member may need to use your name, address, phone number, and your clinical records to contact you to provide phone call, information about treatment alternatives, or other health related information that may be of interest to you. 164.520(b)(l)(iii)(A). If you are not at home to receive the appointment reminder, a message will be left on your machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

Friends &Family
HEALTH CENTERS

Permitted Uses and Disclosures Without Your Consent or Authorization

Under Federal Law, we are also permitted or required to disclose your health information without your consent or authorization in the following circumstances:
1. If we are providing health care services to you based on the orders of another health care provider.
2. If we provide health care services to you as an inmate.
3. If we provide health care services to you in an emergency.
4. If we are required by law to treat you and were unable to obtain your consent after attempting to do so.
5. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples and noted in the uses and disclosures section above, other use or disclosure of your health information will only be made with your written authorization.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:
1. If we have already released your health information before we receive request to revoke your authorization 164.508(b)(5)(i).

2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at our office address, c/o Billing Department.

Your Right to Limit Uses or Disclosures

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know in writing to what individuals or organizations you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your Right to Inspect and Copy Your Health Information

You have the right to request that we give you an account of the disclosures we have made of your health information for the last six years before the date of your request.

Friends & Family
HEALTH CENTERS

The accounting will include all disclosures except these disclosures:

- Required for your treatment, to obtain payment for your services, or to run our practice
- Made to you or to individuals involved in your care
- Necessary to maintain a director of the individuals in our facility
- For national security or intelligence purposes, as required by law
- Made to correction officers or law enforcement officers, as required by law
- That were made prior to the effective date of the HIPAA privacy law

We will provide the first accounting within a 12 month period without charge. There is a fee for any additional requests during the next 12 months. 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.

Your Right to Obtain a Paper Copy of This Notice

If you have agreed to the privacy notices by email, you may request a paper copy of this notice at any time.

Our Duties

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. We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement, we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms, the change will apply for all your health information in our files.

Re-Disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by federal privacy rules.

Your Right To Complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint, and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to Dr. John Palmer or Dr. Belinda McCullen at our office address.