Welcome to

Woodstock, Georgia

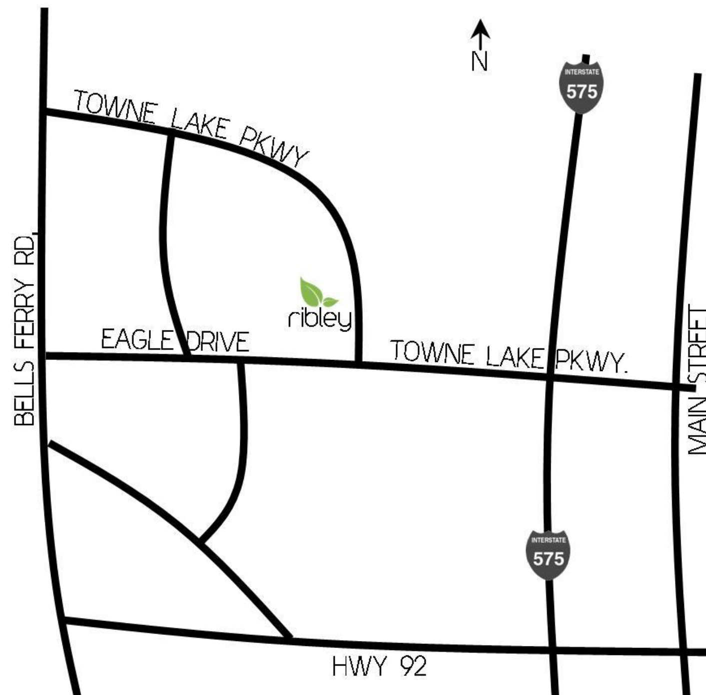
At Ribley Family Chiropractic we value our patients and aim to provide not only the best possible chiropractic care, but a smooth registration process. To make your registration process easier and less timely, this packet contains helpful information and several forms which you should fill out prior to your first visit.

It is important that you read all the forms enclosed in this packet. Please bring the following completed forms to your appointment:

- New Patient Welcome form
- Personal History form
- Healthcare Authorization form

Your insurance card and driver's license will be required for proof of identity and a valid insurance policy. Please have these items available when you register with our Patient Manager on your first visit.

Please arrive 10 minutes prior to your appointment time so that we may review your completed forms and take care of any other administrative details. If you have any questions after reviewing this information please call our office at 734-479-2700.



2453 Towne Lake Parkway, Woodstock GA 30189

from Atlanta/Marietta

- take I-75 North to I-575 North
- take exit 8 -Towne Lake Parkway
- turn left onto Towne Lake Parkway
- as you pass McDonald's stay to the right
- Towne Lake Parkway bears to your right
- at the first traffic light turn left
- The office is immediately on your left

from East Woodstock/Roswell

- Take Hwy 92 West toward downtown Woodstock
- Turn right on I-575 North
- take exit 8 -Towne Lake Parkway
- turn left onto Towne Lake Parkway
- as you pass McDonald's stay to the right
- Towne Lake Parkway bears to your right
- at the first traffic light turn left
- The office is immediately on your left

Office Hours

Monday, Wednesday, Friday 9-12, 3-6:30
Tuesday 3-6
Saturday 8:30-10

Contact Us

2453 Towne Lake Parkway
Woodstock, Georgia 30189

{ph} 770-592-2505

{fax} 770-592-2433

{email} ribleyfc@gmail.com

www.ribleychiro.com

Scheduling Appointments

RFC believes your time is valuable. We see new patients at special times to minimize your wait to see the doctor. This is why we ask that you please give us 48 hours notice when cancelling an appointment. This will give us ample time to restructure our schedule

Payment

Payment is expected at the time of service. Your insurance coverage and payment plans may be discussed with the Financial Counselor at your first visit.

We accept cash, checks and all major credit cards.

ribley family chiropractic

☐ Dr. Jennifer Paulo
☐ Dr. Ken Kilgore
☐ Dr. Niki Sullivan
☐ Dr. Peri Fletcher

New Patient Welcome Form

Name: ______________________________ Date of Birth: ______________________ Age: ________
(full name, please do not use initials) (month/day/year)

Address: ______________________________ City: ______________________ Zip: ________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Referred by: ______________________ Email: ______________________

Marital Status: ☐ Married ______________________
☐ Single
☐ Divorced
☐ Widowed spouse's name

Payment in full is expected at time of service unless prior arrangements have been made.

Number of Children: __________ Ages __________

Your Employer: ______________________ Occupation: ______________________

Who is responsible for your bill? ☐ Self ☐ Spouse ☐ Medicare ☐ Health Insurance ☐ Auto Insurance

Do You have health insurance? ☐Yes ☐ No Insurance Company: ______________________

Primary's: Name: ______________________ Date of Birth: ______________ SS#: ______________

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, to detect and correct/reduce the vertebral subluxation complex. 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 or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method 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 caused alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.
We do not offer to diagnose or treat disease any condition other than vertebral subluxation. 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.
It is understood and agreed the amount paid to Ribley Family Chiropractic for x-ray, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of Ribley Family Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, adjustments, or any other procedure which is advisable and necessary for my health care. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not. I also understand any sum of money paid under assignment by any insurance shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I ______________________________ have read, understand and hereby request chiropractic care based on the above agreement.

Date: ______________________ Signature: ______________________________

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Personal Health History

Name: Date:

Personal Health History

Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:

Address:	City:	St:	Zip:

Date of last Visit: / /	Date of last exam: / /

Have you previously visited a Chiropractor?: ☐ No ☐ Yes, Name of Chiropractor:

Address:	City:	State:	Zip:

Date of last Visit: / /	Date of last exam: / /

How long were you under care?	Why did you leave the practice?

Have you had surgery in the last 5 Years: ☐ Yes ☐ No

Reason for Surgery:

Current Medications:

Please list any side effects:

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	☐ Addiction
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/ hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus

Other:

If history of Cancer, Type: ☐ Breast ☐ Lung ☐ Other: Relationship:

Social History:

Do you:		
smoke? ☐ No ☐ Yes	drink alcohol? ☐ No ☐ Yes
drink caffeine? ☐ No ☐ Yes	use artificial sweetener? ☐ No ☐ Yes
belong to a gym? ☐ No ☐ Yes	drink bottled water? ☐ No ☐ Yes
take vitamins? ☐ No ☐ Yes	eat organic? ☐ No ☐ Yes
have high stress? ☐ No ☐ Yes	exercise regularly? ☐ No ☐ Yes

Females Only:

Is it possible that you are pregnant? ☐ No ☐ Yes- due date:

Date of last menstrual cycle:

Current Symptoms:

General
- ☐Headaches
- ☐Shooting head pain
- ☐Loss of memory
- ☐Fatigue
- ☐Depression
- ☐Dizziness
- ☐Thyroid trouble
- ☐Chills
- ☐Sweats
- ☐Sleeping problems
- ☐Seizures
- ☐Fainting
- ☐Irritability
- ☐Nerves/nervousness
- ☐Inner tension
- ☐Weight gain
- ☐Weight loss
- ☐Twitching of face
- ☐Facial pain
- ☐Jaw pain (TMJ)
- ☐Menstrual cramps
- ☐Menstrual irregularity
- ☐Loss of balance
- ☐Prostate trouble
- ☐Cancer
- ☐Shortness of breath
- ☐Hernia
- ☐Arthritis
- ☐Diabetes
- ☐Painful joints
- ☐Swollen joints
- ☐Ulcers

Gastrointestinal
- ☐Bowel changes
- ☐Intestinal gas
- ☐Constipation
- ☐Indigestion
- ☐Nausea
- ☐Stomach pain
- ☐Stomach trouble
- ☐Vomiting blood
- ☐Vomiting
- ☐Gall bladder trouble

Cardiovascular
- ☐Chest pain
- ☐Heart attacks
- ☐Stroke
- ☐Low blood pressure
- ☐High blood pressure
- ☐Poor circulation
- ☐Irregular heart beat
- ☐Rapid heart beat
- ☐Swollen ankles
- ☐Cold feet
- ☐Anemia

Urinary:
- ☐Bed wetting
- ☐Blood in urine
- ☐Frequent urination
- ☐Lack of bladder control
- ☐Painful urination
- ☐Kidney trouble

Eye/Ear/Nose & Throat
- ☐Sinus trouble
- ☐Loss of smell
- ☐Allergies
- ☐Hay Fever
- ☐Asthma
- ☐Loss of taste
- ☐Inflammation of throat
- ☐Earache
- ☐Hoarseness
- ☐Loss of hearing
- ☐Persistent cough
- ☐Ringing in ears
- ☐Blurred vision
- ☐Vision flashes/halos
- ☐Tonsillitis
- ☐Lights bother eyes

Skin
- ☐Bruise easily
- ☐Hives
- ☐Itching
- ☐Change in moles
- ☐Rash
- ☐Sores that won't heal

Neck
- ☐Neck pain
- ☐Grinding/popping in neck
- ☐Neck stiffness
- ☐Pinched nerve in neck
- ☐Neck feels out of place
- ☐Muscle spasms in neck

Shoulders
- ☐Shoulder/arm tightness
- ☐Shoulder/arm pain
- ☐Pain in shoulder joint
- ☐Pain across shoulders
- ☐Can't raise arms
- ☐Tension in shoulders
- ☐Pinched nerve in shoulders

Arms & Hands
- ☐Pins & needles in arms
- ☐Pins & needles in hands
- ☐Numbness in arms/hands
- ☐Pain in upper arm
- ☐Pain in elbow
- ☐Pain in forearm
- ☐Pain in hand
- ☐Pain in fingers
- ☐Weakness of hand
- ☐Cold hands

Mid Back
- ☐Mid-back pain
- ☐Spinal curvature
- ☐Mid-Back stiffness
- ☐Pain between shoulder blades
- ☐Pain from front to back
- ☐Muscle spasms in Mid-Back

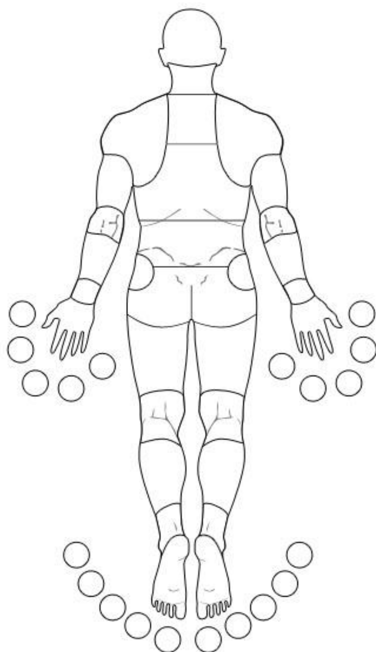
Low Back
- ☐Low back pain
- ☐Low back stiffness
- ☐Low back weakness
- ☐Low back feels out of place
- ☐Muscle spasms in low back

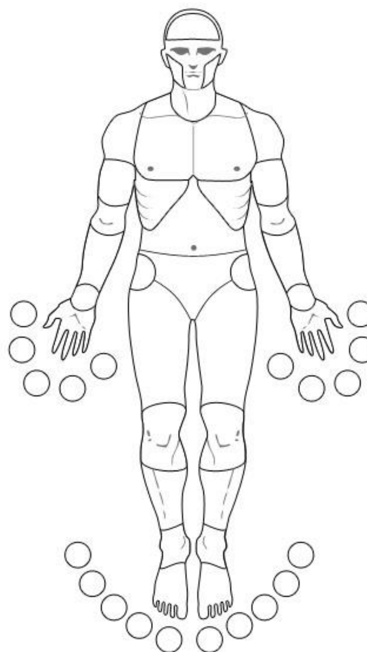
Hips, Legs, & Feet
- ☐Cold feet
- ☐Pain in buttocks
- ☐Pain in hip joint
- ☐Pain down leg
- ☐Pain in knee
- ☐Pain in ankle
- ☐Pain in foot
- ☐Weakness of leg
- ☐Weakness of knee
- ☐Leg cramps
- ☐Pins & needles in legs

Details of Chief Complaint

<table>
<tr><th colspan="2">Complaint History</th></tr>
<tr><td colspan="2">What is your chief complaint?</td></tr>
<tr><td>Is your condition getting worse? ☐ No ☐ Yes
Is it radiating to arms/legs? ☐ No ☐ Yes</td><td>Does it interfere with:
☐Work ☐Sleep ☐Daily routine ☐Exercise</td></tr>
<tr><td>Type of Pain: ☐dull ☐sharp ☐burning ☐throbbing ☐numbness ☐tingling ☐cramps ☐stiffness ☐swelling ☐stabbing</td><td>Rate your Pain:
1 is best, 10 is worst</td></tr>
<tr><td colspan="2">Severity of Pain: ☐Mild (annoyance, no impairment) ☐Slight (some mild impairment) ☐Moderate (marked impairment) ☐Severe (incapacitated/bedridden)</td></tr>
<tr><td colspan="2">Duration of Pain: ☐Intermittent (25% of the time) ☐Occasional (25%-50% of the time) ☐Frequent (50%-75% of the time)☐Constant (76%-100% of the time)</td></tr>
<tr><th>Accidents/Falls History
Please be thorough:</th><th>(such as sports-related, jolts, trauma, etc.). All events that could have any impact upon the spine are of high significance to determine spinal health history.</th></tr>
<tr><td colspan="2">Within the past year
(describe event and when):</td></tr>
<tr><td colspan="2">Over a year ago
(describe event and when):</td></tr>
<tr><td colspan="2">During Childhood
(describe event and when):</td></tr>
</table>

Mark an X on the picture where you experience pain, numbness or tingling:





Healthcare 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 Ribley Family Chiropractic (RFC) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to RFC 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 RFC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

- I give permission to RFC to use my name on a welcome board, referral board, and birthday board.

- I give permission to RFC 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 RFC 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 RFC 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 I am giving RFC permission to use and disclose my protected health information in accordance with the directives listed above.

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

Right to Revoke Authorization

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of RFC. The written notice must contain the following information: Your name, Social Security number, and date of birth; a clear statement of your intent to revoke this AUTHORIZATION; the date of your request; and your signature. The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by RFC for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, RFC will not refuse to provide treatment however, it will not be possible for RFC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since RFC will be unable to contact me 3) all contact with RFC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

I have read and understand this Healthcare Authorization Form, the Right to Revoke Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Social Security Number: XXX-XX-______ Date of birth:

Patient Name: (please print)

Patient's signature
(or parent/guardian): Date:

Name of personal representative
(if applicable)

Description of representative's
authority to act on patient's behalf:

Representative's Signature: Date:

Notice of Privacy Practices

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.

Our Legal Duty

We are required by law to maintain the privacy of protected health information and to provide you with notice of our 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.

Uses and Disclosures

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

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.

Appointment Reminders. *Example:* Your name, address and phone number and health care records may be used to contact you regarding appointment reminders (such as voicemail messages, postcards or letters), information about alternatives to your present care, or other health related information that may be of interest to you.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your**

Acknowledgement or Authorization:

Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly

relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

EXCEPT AS INDICATED ABOVE, YOUR HEALTH INFORMATION WILL NOT BE USED OR DISCLOSED TO ANY OTHER PERSON OR ENTITY WITHOUT YOUR SPECIFIC AUTHORIZATION, WHICH MAY BE REVOKED AT ANY TIME. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

Patient Rights

Right to Request Restrictions. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction. Your request must be made in writing to our Privacy Official.

Right to Receive Confidential Communications. You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled. Your request to receive confidential communications must be made in writing to our Privacy Official.

Right to Inspect and/or Copy. You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. 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 requested amendment.

Right to Receive an Accounting. You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to receive an accounting must be made in writing to our Privacy Official.

Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request.

Complaints

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint.

All questions concerning this Notice or requests made pursuant to it should be addressed to:

Privacy Officer Ribley Family Chiropractic 2453 Towne Lake Parkway Woodstock, GA 30189

EFFECTIVE DATE OF NOTICE: March 24, 2003