

Welcome to



Woodstock, Georgia

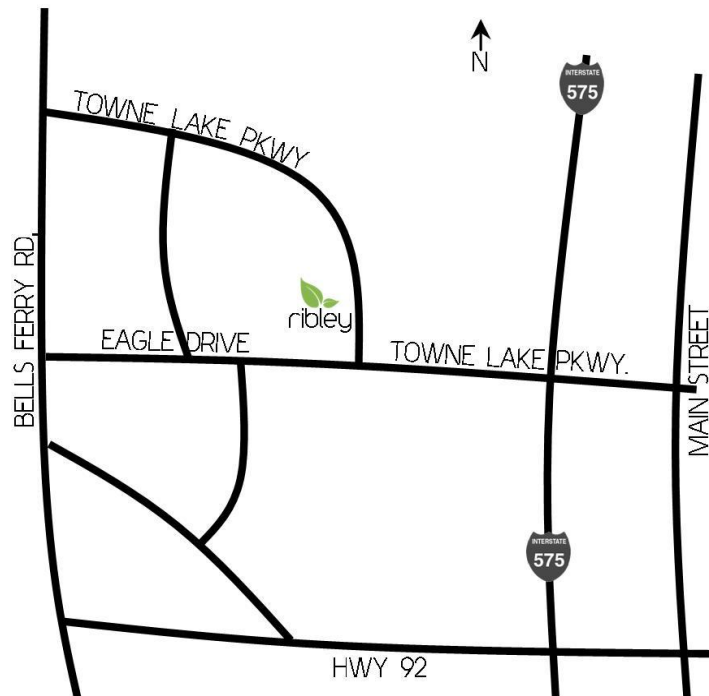
At Ribley Family Chiropractic we value our patients and aim to provide not only the best possible chiropractic care, but a smooth registration process. To make your registration process easier and less timely, this packet contains helpful information and several forms which you should fill out prior 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 770-592-2505.



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} getwell@ribleychiro.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.

- Dr. Jennifer Angerami
- 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 _____ spouse's name
 Single
 Divorced
 Widowed

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: _____

Signature of parent or guardian if minor: _____

Personal Health History

Name:		Date:			
Personal Health History					
Do You Have a Family Doctor?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor:					
Address:		City:	St:	Zip:	
Date of last Visit: / /		Date of last exam: / /			
Have you previously visited a Chiropractor?: <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Reason for Surgery:					
Current Medications:					
Please list any side effects:					
Family History of illness:					
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/> STD'S	<input type="checkbox"/> Addiction
<input type="checkbox"/> Allergies	<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/ hepatitis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Polio
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diverticulitis
Other:					
If history of Cancer, Type: <input type="checkbox"/> Breast <input type="checkbox"/> Lung <input type="checkbox"/> Other: Relationship:					
Social History:					
Do you:		smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes	drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes		
		drink caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes	use artificial sweetener? <input type="checkbox"/> No <input type="checkbox"/> Yes		
		belong to a gym? <input type="checkbox"/> No <input type="checkbox"/> Yes	drink bottled water? <input type="checkbox"/> No <input type="checkbox"/> Yes		
		take vitamins? <input type="checkbox"/> No <input type="checkbox"/> Yes	eat organic? <input type="checkbox"/> No <input type="checkbox"/> Yes		
		have high stress? <input type="checkbox"/> No <input type="checkbox"/> Yes	exercise regularly? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Females Only:					
Is it possible that you are pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes- due date:					
Date of last menstrual cycle:					

Current Symptoms:

<p>General</p> <input type="checkbox"/> Headaches <input type="checkbox"/> Shooting head pain <input type="checkbox"/> Loss of memory <input type="checkbox"/> Fatigue <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Thyroid trouble <input type="checkbox"/> Chills <input type="checkbox"/> Sweats <input type="checkbox"/> Sleeping problems <input type="checkbox"/> Seizures <input type="checkbox"/> Fainting <input type="checkbox"/> Irritability <input type="checkbox"/> Nerves/nervousness <input type="checkbox"/> Inner tension <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Twitching of face <input type="checkbox"/> Facial pain <input type="checkbox"/> Jaw pain (TMJ) <input type="checkbox"/> Menstrual cramps <input type="checkbox"/> Menstrual irregularity <input type="checkbox"/> Loss of balance <input type="checkbox"/> Prostate trouble <input type="checkbox"/> Cancer <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Hernia <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Painful joints <input type="checkbox"/> Swollen joints <input type="checkbox"/> Ulcers	<p>Gastrointestinal</p> <input type="checkbox"/> Bowel changes <input type="checkbox"/> Intestinal gas <input type="checkbox"/> Constipation <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach pain <input type="checkbox"/> Stomach trouble <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Vomiting <input type="checkbox"/> Gall bladder trouble	<p>Eye/Ear/Nose & Throat</p> <input type="checkbox"/> Sinus trouble <input type="checkbox"/> Loss of smell <input type="checkbox"/> Allergies <input type="checkbox"/> Hay Fever <input type="checkbox"/> Asthma <input type="checkbox"/> Loss of taste <input type="checkbox"/> Inflammation of throat <input type="checkbox"/> Earache <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Blurred vision <input type="checkbox"/> Vision flashes/halos <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Lights bother eyes	<p>Neck</p> <input type="checkbox"/> Neck pain <input type="checkbox"/> Grinding/popping in neck <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Pinched nerve in neck <input type="checkbox"/> Neck feels out of place <input type="checkbox"/> Muscle spasms in neck	<p>Mid Back</p> <input type="checkbox"/> Mid-back pain <input type="checkbox"/> Spinal curvature <input type="checkbox"/> Mid-Back stiffness <input type="checkbox"/> Pain between shoulder blades <input type="checkbox"/> Pain from front to back <input type="checkbox"/> Muscle spasms in Mid-Back
	<p>Cardiovascular</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Heart attacks <input type="checkbox"/> Stroke <input type="checkbox"/> Low blood pressure <input type="checkbox"/> High blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swollen ankles <input type="checkbox"/> Cold feet <input type="checkbox"/> Anemia	<p>Skin</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Sores that won't heal	<p>Shoulders</p> <input type="checkbox"/> Shoulder/arm tightness <input type="checkbox"/> Shoulder/arm pain <input type="checkbox"/> Pain in shoulder joint <input type="checkbox"/> Pain across shoulders <input type="checkbox"/> Can't raise arms <input type="checkbox"/> Tension in shoulders <input type="checkbox"/> Pinched nerve in shoulders	<p>Low Back</p> <input type="checkbox"/> Low back pain <input type="checkbox"/> Low back stiffness <input type="checkbox"/> Low back weakness <input type="checkbox"/> Low back feels out of place <input type="checkbox"/> Muscle spasms in low back
			<p>Arms & Hands</p> <input type="checkbox"/> Pins & needles in arms <input type="checkbox"/> Pins & needles in hands <input type="checkbox"/> Numbness in arms/hands <input type="checkbox"/> Pain in upper arm <input type="checkbox"/> Pain in elbow <input type="checkbox"/> Pain in forearm <input type="checkbox"/> Pain in hand <input type="checkbox"/> Pain in fingers <input type="checkbox"/> Weakness of hand <input type="checkbox"/> Cold hands	<p>Hips, Legs, & Feet</p> <input type="checkbox"/> Cold feet <input type="checkbox"/> Pain in buttocks <input type="checkbox"/> Pain in hip joint <input type="checkbox"/> Pain down leg <input type="checkbox"/> Pain in knee <input type="checkbox"/> Pain in ankle <input type="checkbox"/> Pain in foot <input type="checkbox"/> Weakness of leg <input type="checkbox"/> Weakness of knee <input type="checkbox"/> Leg cramps <input type="checkbox"/> Pins & needles in legs

Details of Chief Complaint

Complaint History

What is your chief complaint?

Is your condition getting worse? No Yes

Does it interfere with:

Is it radiating to arms/legs? No Yes

Work Sleep Daily routine Exercise

Type of Pain: dull sharp burning throbbing numbness
 tingling cramps stiffness swelling stabbing

Rate your Pain:
 1 is best, 10 is worst

Severity of Pain: Mild (annoyance, no impairment) Slight (some mild impairment)
 Moderate (marked impairment) Severe (incapacitated/bedridden)

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)

Accidents/Falls History

(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.

Please be thorough:

Within the past year

(describe event and when):

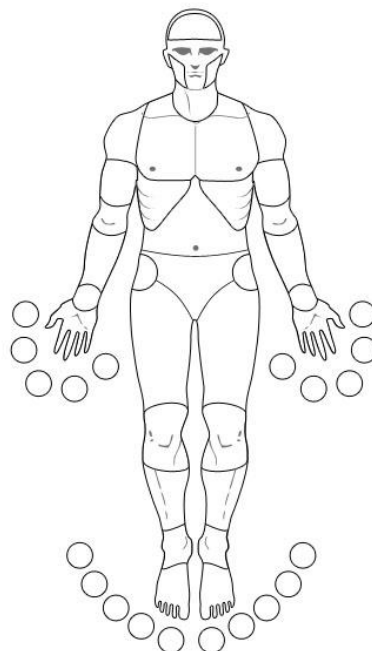
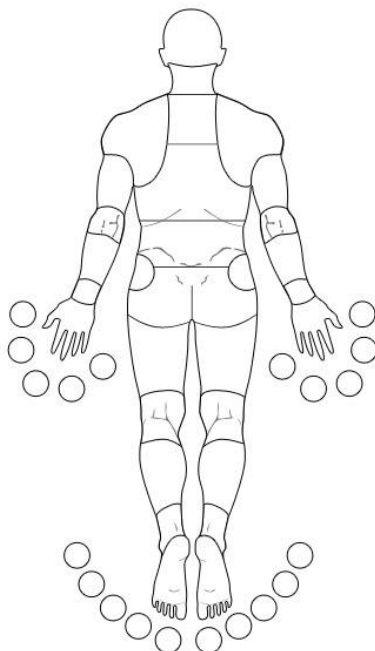
Over a year ago

(describe event and when):

During Childhood

(describe event and when):

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



Motor Vehicle Accident Information

Patient Name :	Social Security #:
Date of Accident:	
<input type="checkbox"/> I was the driver <input type="checkbox"/> I was the passenger seated in the <input type="checkbox"/> front <input type="checkbox"/> rear left <input type="checkbox"/> rear middle <input type="checkbox"/> rear right	

Patients Vehicle:	Type:	<input type="checkbox"/> Car <input type="checkbox"/> Van <input type="checkbox"/> Truck <input type="checkbox"/> Bus <input type="checkbox"/> SUV <input type="checkbox"/> Motor Cycle
	Size:	<input type="checkbox"/> Mini <input type="checkbox"/> Sub Comp <input type="checkbox"/> Compact <input type="checkbox"/> Mid Size <input type="checkbox"/> Full Size
	Action:	<input type="checkbox"/> Stopped <input type="checkbox"/> Slowing <input type="checkbox"/> Acceleration <input type="checkbox"/> Cruising
	Speed:	approximately _____ MPH
	Time:	<input type="checkbox"/> Day Light <input type="checkbox"/> Dawn <input type="checkbox"/> Dusk <input type="checkbox"/> Dark
	Road Condition:	<input type="checkbox"/> Dry <input type="checkbox"/> Damp <input type="checkbox"/> Wet <input type="checkbox"/> Snow <input type="checkbox"/> Ice
	Visibility:	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Enter impact information for up to three Vehicles or Objects

Impact Information: Vehicle or Object (I)

Collision with a	Name Object :	
<input type="checkbox"/> Vehicle	Vehicle Type :	<input type="checkbox"/> Car <input type="checkbox"/> Van <input type="checkbox"/> Pickup <input type="checkbox"/> Truck <input type="checkbox"/> Bus <input type="checkbox"/> SUV <input type="checkbox"/> M. Cycle
<input type="checkbox"/> Object	Size :	<input type="checkbox"/> Mini <input type="checkbox"/> Sub Comp <input type="checkbox"/> Compact <input type="checkbox"/> Mid Size <input type="checkbox"/> Full Size
	Car Damage:	<input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Extensive <input type="checkbox"/> Totaled <input type="checkbox"/> Unsure

Impact Information: Vehicle or Object (II)

Collision with a	Name Object :	
<input type="checkbox"/> Vehicle	Vehicle Type :	<input type="checkbox"/> Car <input type="checkbox"/> Van <input type="checkbox"/> Pickup <input type="checkbox"/> Truck <input type="checkbox"/> Bus <input type="checkbox"/> SUV <input type="checkbox"/> M. Cycle
<input type="checkbox"/> Object	Size :	<input type="checkbox"/> Mini <input type="checkbox"/> Sub Comp <input type="checkbox"/> Compact <input type="checkbox"/> Mid Size <input type="checkbox"/> Full Size
	Car Damage:	<input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Extensive <input type="checkbox"/> Totaled <input type="checkbox"/> Unsure

Impact Information: Vehicle or Object (III)

Collision with a	Name Object :	
<input type="checkbox"/> Vehicle	Vehicle Type :	<input type="checkbox"/> Car <input type="checkbox"/> Van <input type="checkbox"/> Pickup <input type="checkbox"/> Truck <input type="checkbox"/> Bus <input type="checkbox"/> SUV <input type="checkbox"/> M. Cycle
<input type="checkbox"/> Object	Size :	<input type="checkbox"/> Mini <input type="checkbox"/> Sub Comp <input type="checkbox"/> Compact <input type="checkbox"/> Mid Size <input type="checkbox"/> Full Size
	Car Damage:	<input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Extensive <input type="checkbox"/> Totaled <input type="checkbox"/> Unsure

During Impact Information:

Seat Belt?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Brakes Applied ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Air Bag Deployed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seat Broken ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seat Back position Changed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Head Rest:	Low / Mid / High / None				
Impact was:	Un-expected / Expected / Expected and Braced				
Body Position:	Straight / Rotated Left / Rotated Right / Unsure / Other:				
Body Thrown?	<input type="checkbox"/> Yes / <input type="checkbox"/> No				
Direction of Throw:	Backwards / Forward / Outside / Unsure / Other:				
Head Position:	Straight / Rotated Left / Rotated Right / Forward / Unsure / Other:				
Head Motion:	Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other:				

Body Impact (Indicate any parts of your body that were struck during the impact)

<input type="checkbox"/> Head	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Right hand	<input type="checkbox"/> Lower Back
<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Left Leg	<input type="checkbox"/> Mid Torso	<input type="checkbox"/> Right Foot
<input type="checkbox"/> Left Arm	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Mid Back	<input type="checkbox"/> Left Foot
<input type="checkbox"/> Left Elbow	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Right Knee	<input type="checkbox"/> Other :
<input type="checkbox"/> Left hand	<input type="checkbox"/> Right Arm	<input type="checkbox"/> Left Knee	
<input type="checkbox"/> Upper Front Torso	<input type="checkbox"/> Right Elbow	<input type="checkbox"/> Lower Front Torso	

After Accident Information:

Immediately After Accident:	<input type="checkbox"/> Dizzy/dazed <input type="checkbox"/> Upset <input type="checkbox"/> Weak <input type="checkbox"/> Nervous <input type="checkbox"/> Headache <input type="checkbox"/> Disoriented <input type="checkbox"/> Unconscious <input type="checkbox"/> /Other:
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Pain immediately after accident:

<input type="checkbox"/> Head	<input type="checkbox"/> Left foot	<input type="checkbox"/> Right foot	<input type="checkbox"/> Left Knee
<input type="checkbox"/> Left Hand	<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Right knee
<input type="checkbox"/> Right Arm	<input type="checkbox"/> Left Elbow	<input type="checkbox"/> Left Arm	<input type="checkbox"/> Other :
<input type="checkbox"/> Upper Front Torso	<input type="checkbox"/> Mid Torso	<input type="checkbox"/> Right elbow	
<input type="checkbox"/> Upper Back	<input type="checkbox"/> Mid back	<input type="checkbox"/> Lower Front Torso	
<input type="checkbox"/> Left Leg	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Lower Back	

Numbness immediately after accident:

<input type="checkbox"/> Left Hand	<input type="checkbox"/> Right Hand	<input type="checkbox"/> Left Leg	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Upper Arm
<input type="checkbox"/> Right Upper Arm	<input type="checkbox"/> Left Foot	<input type="checkbox"/> Right Foot	<input type="checkbox"/> Other:	

Medical Information (Did you get medical care for this accident before coming to our office)

Medical Care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Time of care:	<input type="checkbox"/> Next day <input type="checkbox"/> At time of Accident <input type="checkbox"/> Later that Day <input type="checkbox"/> Days Later: (Specify)
Transportation:	<input type="checkbox"/> Drove Self <input type="checkbox"/> Ambulance <input type="checkbox"/> Other
Went To:	<input type="checkbox"/> Orthopedic <input type="checkbox"/> Chiropractor <input type="checkbox"/> Neurologist <input type="checkbox"/> Family Doc <input type="checkbox"/> ER <input type="checkbox"/> Other(Specify)
Admitted to Hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No Days Spent in Hospital:
Test:	<input type="checkbox"/> X-ray <input type="checkbox"/> Lab Work <input type="checkbox"/> MRI <input type="checkbox"/> CT Scan <input type="checkbox"/> Other(Specify)
Treatment:	<input type="checkbox"/> Ice Pack <input type="checkbox"/> Hot Pack <input type="checkbox"/> Cervical Collar <input type="checkbox"/> Medication <input type="checkbox"/> None <input type="checkbox"/> Other(Specify)

Previous Injuries

Previous Injuries / Accidents	<input type="checkbox"/> No <input type="checkbox"/> Yes, Specify:
Residual pain from Previous Injuries/Accidents	<input type="checkbox"/> No <input type="checkbox"/> Yes, Specify:

Later Symptoms (Please note any symptoms that started after the accident occurred)

Head	<input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Light Headedness <input type="checkbox"/> Loss of Vision <input type="checkbox"/> Fainting <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Pain in ear <input type="checkbox"/> Double Vision <input type="checkbox"/> Other Specify:
Neck (with Movement)	<input type="checkbox"/> Pain in Neck <input type="checkbox"/> Forward <input type="checkbox"/> Backward <input type="checkbox"/> Turn Left <input type="checkbox"/> Popping in Neck <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Turn Right <input type="checkbox"/> Bend Left <input type="checkbox"/> Bend Right <input type="checkbox"/> Other Specify:
Shoulders	<input type="checkbox"/> Pain in Shoulder joint <input type="checkbox"/> Tension in shoulders <input type="checkbox"/> Muscle Spasms in Shoulder <input type="checkbox"/> Pain across shoulder <input type="checkbox"/> Cant raise arms above [] Above shoulder level [] Over head <input type="checkbox"/> Other Specify:
Arms and Hands	<input type="checkbox"/> Pain in Fingers <input type="checkbox"/> Numbness in Left Arm <input type="checkbox"/> Hands Cold <input type="checkbox"/> Pin & needles in hands <input type="checkbox"/> Numbness in Right Arm <input type="checkbox"/> Loss of Grip Strength <input type="checkbox"/> Pin & needles in fingers <input type="checkbox"/> Swollen joints in Fingers <input type="checkbox"/> Other Specify:
Chest	<input type="checkbox"/> Chest pain <input type="checkbox"/> Pain Around Ribs <input type="checkbox"/> Shortness of Breadth <input type="checkbox"/> Breast Pain <input type="checkbox"/> Other Specify:
Abdomen	<input type="checkbox"/> Nervous Stomach <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Gas <input type="checkbox"/> Constipation <input type="checkbox"/> Other Specify:
Mid back	<input type="checkbox"/> Sharp Stabbing <input type="checkbox"/> Mid pain back <input type="checkbox"/> Pain From front to back <input type="checkbox"/> Dull Ache <input type="checkbox"/> Pain in Kidney Area <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Other Specify:
Lower Back	<input type="checkbox"/> Low Back Pain Low back pain is worse when: <input type="checkbox"/> Working <input type="checkbox"/> Lifting <input type="checkbox"/> Stooping <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Bending <input type="checkbox"/> Coughing <input type="checkbox"/> Lying Down <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Other Specify:
Hips, Legs & Feet	<input type="checkbox"/> Pain in Buttocks <input type="checkbox"/> Pain and needles in Legs <input type="checkbox"/> Pain down leg <input type="checkbox"/> Pain in hip joint <input type="checkbox"/> Feet feel Cold <input type="checkbox"/> Swollen Feet <input type="checkbox"/> Numbness in Toes <input type="checkbox"/> Numbness of Leg <input type="checkbox"/> Knee pain <input type="checkbox"/> Leg cramps <input type="checkbox"/> Cramps in Feet

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.

healthcare authorization form continued...

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 your 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 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 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