

ACCEPTANCE OF CHIROPRACTIC CARE

Thank you for choosing Dr. Nygaard and Atlas Family Chiropractic in your search for optimal health. Our mission is to provide lasting pain relief while maximizing the health potential of those families that seek our care. We provide state of the art chiropractic care and educational resources that serve to motivate our patients to seek a wellness lifestyle, with an attitude of self responsibility for their health.

The purpose of today's visit is to determine the exact nature of your problem and if you can be helped by the approach we utilize in our office. It is equally important that we ensure each patient understand our objectives and the methods we use. This will minimize the potential for confusion or disappointment. Our approach involves correction of vertebral subluxation by specific chiropractic adjustments.

Adjustment: An adjustment is the specific application of force with the intention of facilitating the correction of vertebral subluxation. Our Chiropractic adjustments are gentle and specific

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which can adversely affect the functioning of the nerve system, leading to compromised health and overall well being. This reduced function can lead to a myriad of health concerns and is in no way limited to pain.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, 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.

If Dr. Nygaard determines the necessity, I authorize him to perform x-rays. They will be used to locate and analyze the presence of vertebral subluxation.

Please initial _____

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

(Signature)

(Date)

VERIFICATION OF NON-PREGNANCY- By my signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected at this particular time.

Date of last menstrual period _____ Please initial _____

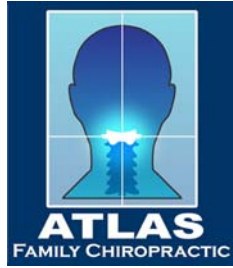
I, _____, have read and fully understand the above statements.

Thank you for choosing Atlas Family Chiropractic.
 In order to serve you properly, we will need the following information in as much detail as possible.

PLEASE PRINT

All information is strictly confidential.

Patient's Name (First, MI, Last)		Preferred Name		Birth Date	Age	Marital Status <i>(please circle)</i> M S D W Sig Other	
Patient's Address		City	State	Zip	Home Phone		Cell Phone
If Minor, Parent or Legal Guardian's name		Email Address (for newsletters etc)			Height		Weight
Name of Employer		Employment Address (w/ city, state, zip)				Business Phone	
Occupation		Social Security Number			Driver's License Number		
Spouse's Name		Spouse's Employer		Spouse's Birth Date		Spouse's Social Security	
Emergency Contact		Relationship to Patient			Best Phone Number		
Do you have Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide a copy of your insurance or Medicare card.</i>		Who may we thank for referring you to Atlas Family Chiropractic?					
Consent to Treat a Minor: <i>I hereby authorize the doctors and staff at Atlas Family Chiropractic to deliver treatment services to my:</i> <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Grandson <input type="checkbox"/> Granddaughter <input type="checkbox"/> _____							
Name of Child: _____ City: _____ State: _____							
Date Signed:		Signature:			Witness:		
Patient or Authorized Person's Signature: <i>I authorize request of any medical information necessary to process this claim and request payment of government benefits either to myself or to the party who accepts assignment below.</i>							
Signature: _____ Date: _____							



HEALTH INFORMATION

NAME: _____

DATE: _____

Main Complaint	How Intense? 0=least; 10 = Worst (Please Circle One)	How Frequent: 100% 75% 50% 25% (Please Circle One)	Is pain getting Worse, Better or Same? (Please Circle One)
1.	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	Worse Better Same
2.	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	Worse Better Same
3.	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	Worse Better Same
4.	0 1 2 3 4 5 6 7 8 9 10	100% 75% 50% 25%	Worse Better Same

Date of onset of injury or symptoms: _____

Have you ever had a similar condition? No _____ Yes _____ Please describe _____

What activities aggravate your condition? _____

Are injuries or symptoms work related? No _____ Yes _____ Auto Accidents _____

Have any of the following been affected? Work _____ Sleep _____ Daily routine _____ Other _____

Have you seen a doctor or chiropractor for this condition? No _____ Yes _____

Name of chiropractor _____ Date of Last Visit _____

Name of medical doctor _____ Date of Last Visit _____

What do you think caused this condition? _____

When was the last time you really felt well? _____

Have you been treated for any other health conditions this year? No _____ Yes _____

Please describe _____

What operations have you had and when? _____

Fractured bones? _____

What medications are you taking? _____

Do you wear? Heel Lifts _____ Arch Supports _____

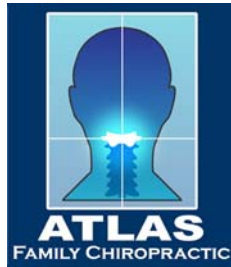
Have You Ever Suffered From?

- Allergy
- Dizziness
- Fatigue
- Headache
- Loss of Sleep
- Ulcers
- Nervousness/Depression
- Numbness
- Arthritis
- Bursitis
- Foot Trouble
- Low Back Pain
- Neck pain or Stiffness
- Poor Posture
- Sciatica
- Spinal curvatures
- Swollen Joints
- Colon trouble
- Diarrhea
- Difficult Digestion
- Hemorrhoids
- Nausea
- Asthma
- Colds
- Deafness
- Ear Noises
- Enlarged Thyroid
- Eye Pain
- Failing Vision
- Venereal diseases
- Tuberculosis
- Bruise Easily
- Hay Fever
- Nose Bleeds
- Sinus Infection
- High Blood Pressure
- Low Blood Pressure
- Pain over Heart
- Poor Circulation
- Rapid Heart Beat
- Slow Heart Beat
- Anemia
- Stroke

- Chest Pain
- Difficulty Breathing
- Pleurisy
- Swelling of the Ankles
- Cancer
- Bed-wetting
- Frequent Urination
- Kidney Infection or Stone
- Prostate trouble
- Cramps or Backache
- Excessive Menstrual Flow
- Hot flashes
- Irregular period cycle
- Lumps in Breasts
- Alcoholism
- Diabetes
- Polio

Tingling or Numbness In:

- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet



PRIVACY ACT LAW

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

In the course of your care as a patient at Atlas Family Chiropractic we may use or disclose personal and health related information about in the following ways:

1. Your personal health information including your clinical records may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
2. Your health care records as well as your billing records may be disclosed to another party such as an insurance carrier, an HMO a PPO or your employer if they are or may be responsible for the payment of your services.
3. Your name, address, phone number and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted and/or required to use or disclose your health information without your consent or authorization in these 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 in an emergency.
3. If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
4. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
5. If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preference.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

(Please See Back of Form)

(Privacy Act Cont.)

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

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

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. David Nygaard

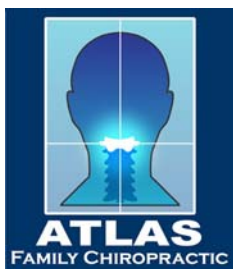
This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (please print) _____ Signature _____ Date _____

If you are a minor, or if you are being represented by another party

Personal Representative (please print) _____

Personal Representative Signature _____ Date _____



PATIENT AUTHORIZATION FOR APPOINTMENT REMINDERS

It is our desire for our staff to use your name, address, telephone number and email address for the purpose of contacting you to remind you about scheduled appointments, re-evaluations, and other appointment related issues.

Your signature indicates your authorization of this activity.

Name (printed)

Signature

Date

PATIENT AUTHORIZATION OF NOTIFICATION OF CHIROPRACTIC RELATED CARE, RELATED HEALTH SERVICES AND WORKSHOPS

It is our desire for our staff to use your name, address, telephone number and email address for the purposes of contacting you to advise you about health related meetings and workshops. This information is for Atlas Family Chiropractic only and will not be given externally.

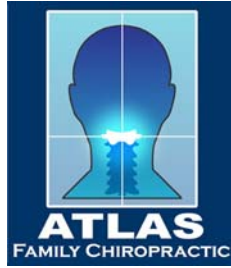
Your signature indicates your authorization of this activity.

Name (printed)

Signature

Date

If you choose not to authorize this information, your decision will have no adverse effect on your care from Dr. Nygaard or on your relationship with staff members. These authorizations may be revoked by you at any time in writing. Please allow a reasonable processing time for the change in our system to be completed.



FINANCIAL AGREEMENT

1. This office will verify the coverage of your insurance policy and the reimbursement rates. We do not guarantee coverage by insurance companies for the services provided by this office.
2. This office will provide our records and file the appropriate billing information to your insurance company as a complimentary service to you. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis. Any insurance denials are, therefore your responsibility.
3. I understand that if I suspend or terminate my schedule of care as specified by my doctor that any outstanding fees for professional services will become immediately due and payable.
4. I am entitled to stop care at any time. If I stop care for any reason and have prepaid for services at a discounted rate, that discount will be null and void. I will pay for all services received at the usual non-discounted rate. Any balance due me will be adjusted to reflect the usual rate and refunded.
5. Scheduled office visits require a 24 hour notice of cancellation. I understand and agree that if I do not provide proper notice I become responsible for the usual and customary charge for office visits (\$40).

Consent For Treatment:

I voluntarily consent to the rendering of care, including treatments and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician(s) and it is the responsibility of the staff to carry out the instructions of such physician(s).

Assignment of Benefits:

I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges, which the insurance carrier declines to pay. It is further agreed that any credit or balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician by the insured or his/her family.

Release Information:

The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient for all or part of the physician(s) charges, including but not limited to, insurance companies, Worker's Compensation carriers, welfare funds or the patient's employer.

Medicare and Medicaid Patient Certification – Payments Certification Authorization To Release Information and Payment Request:

I certify that the information given by me in applying for payment under Title XVIII and/or XI of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I understand that I am responsible for my health insurance deductible and co-insurance.

I have read, understand and agree to comply with the above financial arrangements. If you have insurance your co-pay or percentage will be expected on the day of service. If you do not have insurance, payment in full will be expected for any charges incurred on the day of service.

Print Patient's Name _____

Patient's Signature _____

Parent or Guardian Signature If Patient Is A Minor _____

Relationship _____