**_Alabama Chiropractic Spine & Joint Clinic_** **(256) 284-7179**

Dr. Bailey Carroll DC

100 Pinebrook Dr.
Florence, AL 35633

DATE: _____

***PATIENT DATA***

FIRST NAME:_____ MI: _____ LAST NAME: _____

BIRTH DATE: _____ AGE: _____ SOCIAL SECURITY #: _____ MARITAL STATUS: _____

SPOUSE'S NAME: _____ **HOW DID YOU HEAR ABOUT US:** _____

***MAILING ADDRESS***

ADDRESS:_____ CITY:_____ STATE: _____ ZIP:_____

EMAIL ADDRESS: _____ **YOUR EMAIL WILL NOT BE SHARED **

HOME #: _____ CELL #: _____ WORK #: _____

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT: _____ CONTACT #: _____

***CURRENT COMPLAINTS***

*NATURE OF INJURY:* ☐ **AUTOMOBILE** ☐ **WORK** ☐ **OTHER** DATE OF INJURY/ SYMPTOMS APPEARED: _____

HAVE YOU EVER HAD SAME CONDITION ☐ NO ☐ YES IF YES, WHEN : _____

HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE ☐ NO ☐ YES IF YES, WHEN : _____

LIST OF OTHER PRACTITIONERS SEEN FOR THIS INJURY/ CONDITION: _____

BRIEFLY DESCRIBE THE COMPLAINTS YOU ARE SEEKING TREATMENT FOR:_____

_____

WHEN DID THE SYMPTOMS START?_____ _____

***INSURANCE INFORMATION***

NAME OF PERSON RESPONSIBLE FOR PAYMENT: _____ PHONE: _____

DO YOU HAVE HEALTH INSURANCE ☐ NO ☐ YES NAME OF COMPANY: _____

*** IF INJURY IS DUE TO AUTO ACCIDENT or WORKMAN'S COMP PLEASE PROVIDE INFORMATION ***

INSURANCE COMPANY _____ CONTACT PERSON _____

PHONE #: _____ CLAIM #_____

ATTORNEY: _____ PHONE: _____

***SIGNATURES***

NAME OF THE INSURED: _____

*I understand and agree*

PATIENT'S SIGNATURE _____ DATE _____

SPOUSE'S OR GUARDIAN'S SIGNATURE _____ DATE _____

***MEDICAL HISTORY***

HAVE YOU BEEN TREATED FOR ANY CONDITIONS IN THE LAST YEAR ☐ NO ☐ YES

IF YES, PLEASE DESCRIBE _____

DATE OF LAST PHYSICAL EXAM _____ IS THERE A CHANCE YOU ARE PREGNANT ☐ NO ☐ YES

HAVE YOU HAD X-RAYS TAKEN ☐NO ☐YES IF YES, WHERE _____

| *HAVE YOU EVER:* | *NO* | *YES* | *BRIEFLY EXPLAIN* |
|---|---|---|---|
| BROKEN BONES | ☐ | ☐ | |
| BEEN HOSPITALIZED | ☐ | ☐ | |
| BEEN IN AN AUTO ACCIDENT | ☐ | ☐ | |
| HAD SPRAINS/STRAINS | ☐ | ☐ | |
| BEEN STRUCK UNCONSCIOUS | ☐ | ☐ | |
| HAD SURGERY | ☐ | ☐ | |
| HIV/ STD | ☐ | ☐ | |

| | *NO* | *YES* |
|---|---|---|
| DO YOU EXPERIENCE PAIN EVERY DAY | ☐ | ☐ |
| DO YOUR SYMPTOMS INTERFERE WITH DAILY LIFE | ☐ | ☐ |
| DOES PAIN WAKE YOU UP AT NIGHT | ☐ | ☐ |
| ARE YOUR SYMPTOMS WORSE DURING CERTAIN TIMES OF THE DAY | ☐ | ☐ |
| DO CHANGES IN WEATHER AFFECT YOUR SYMPTOMS | ☐ | ☐ |
| DO YOU WEAR ORTHOTICS | ☐ | ☐ |
| DO YOU TAKE VITAMIN SUPPLEMENTS | ☐ | ☐ |

WHAT ACTIVITIES AGGRAVATE YOUR SYMPTOMS _____

_____

_____

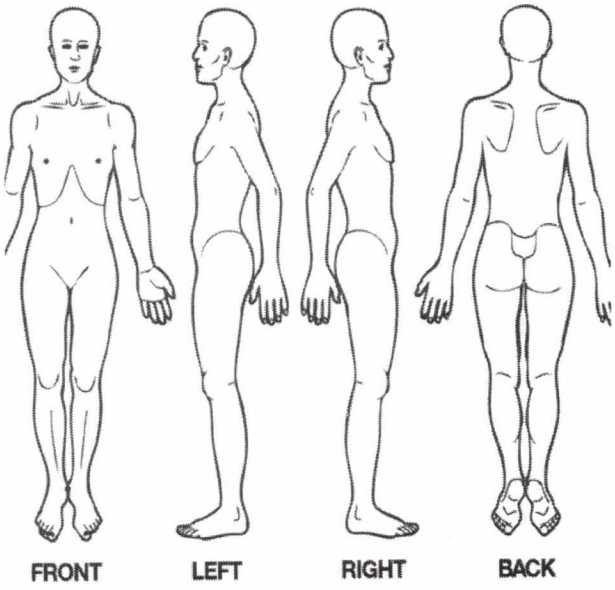
| *HABITS* | *NONE* | *LIGHT* | *MODERATE* | *HEAVY* | *HOW OFTEN / HOW MANY* |
|---|---|---|---|---|---|
| ALCOHOL | ☐ | ☐ | ☐ | ☐ | |
| COFFEE | ☐ | ☐ | ☐ | ☐ | |
| TOBACCO | ☐ | ☐ | ☐ | ☐ | |
| DRUGS | ☐ | ☐ | ☐ | ☐ | |
| EXERCISE | ☐ | ☐ | ☐ | ☐ | |
| SLEEP | ☐ | ☐ | ☐ | ☐ | |
| APPETITE | ☐ | ☐ | ☐ | ☐ | |
| SOFT DRINKS | ☐ | ☐ | ☐ | ☐ | |
| WATER | ☐ | ☐ | ☐ | ☐ | |
| SALTY FOODS | ☐ | ☐ | ☐ | ☐ | |
| SUGARY FOODS | ☐ | ☐ | ☐ | ☐ | |
| ARTIFICIAL SWEETENERS | ☐ | ☐ | ☐ | ☐ | |

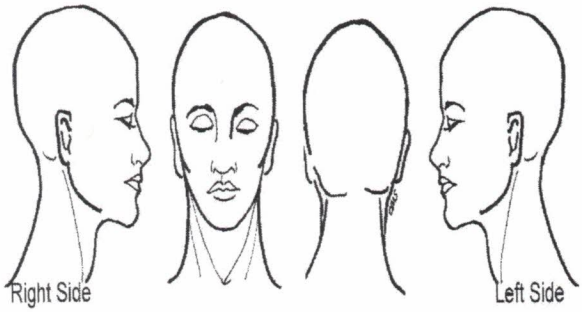
***HAVE YOU EVER SUFFERED FROM:***

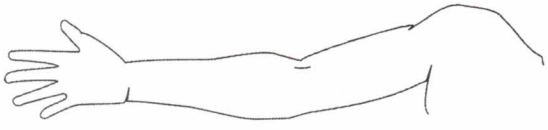
- ☐ ALCOHOLISM
- ☐ ALLERGIES
- ☐ ANEMIA
- ☐ ARTERIOSCLEROSIS
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BACK PAIN
- ☐ BREAST LUMP
- ☐ CANCER
- ☐ CHEST PAIN / CONDITIONS
- ☐ COLD EXTREMITIES
- ☐ CONSTIPATION
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIZZINESS
- ☐ EARS RINGING
- ☐ FATIGUE
- ☐ FREQUENT URINATION
- ☐ HEADACHE
- ☐ HIGH BLOOD PRESSURE
- ☐ IRREGULAR HEART BEAT
- ☐ LOSS OF MEMORY
- ☐ LOSS OF BALANCE
- ☐ NECK PAIN OR STIFFNESS
- ☐ NOSEBLEEDS
- ☐ PACEMAKER
- ☐ POLIO
- ☐ PROSTATE TROUBLE
- ☐ SHORTNESS OF BREATH
- ☐ STROKE
- ☐ SWELLING OF ANKLES
- ☐ SWOLLEN JOINTS
- ☐ THYROID CONDITION
- ☐ TUBERCULOSIS
- ☐ ULCERS
- ☐ VARICOSE VEINS
- ☐ VENEREAL DISEASE
- ☐ OTHER _____

***Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.***

**A**= Ache
**B**= Burning
**N**= Numbness
**O**= Other
**P**=Pins & Needles
**S**= Stabbing



***Alabama Chiropractic Spine & Joint Clinic*** **(256) 284-7179**

Dr. Bailey Carroll, D.C.

100 Pinebrook Dr.
Florence, AL 35633

# New Patient Intake Form
# Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible:_____) by the chiropractic physician and/ or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the physician at Alabama Chiropractic Spine and Joint Clinic and / or other licensed Physicians of Chiropractic who may treat me now or in the future at the office. I have had an opportunity to discuss with the Doctor and / or with office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risk to treatment; including, but not limited to: fractures, disc injuries, stroke (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgement during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____
Print Patient's Name

_____
Signature of Patient

Date:_____/_____/_____

To be completed by patient's representative, if necessary, (e.g., if the patient is a minor or is physically or mentally incapacitated)

_____
Print Name of Representative

_____
Signature of Representative

Date:_____/_____/_____

Physician Signature _____ _____ Date:_____/_____/_____

***Alabama Chiropractic Spine & Joint Clinic*** **(256) 284-7179**

Dr. Bailey Carroll, DC

100 Pinebrook Dr.
Florence, AL 35633

**Assignment, Lien, and Authorization**
**Insurance Benefits and Attorney**

To whom it may concern,

I, _____ hereby authorize and direct you, my insurance company, and / or my attorney, to pay directly to Alabama Chiropractic Spine & Joint Clinic, Inc. such sums as may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due in this office, and to withhold such sums from any disability benefits, medical payments benefits, No-Fault benefits, health and accident benefits, workman's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to as an assignment of my rights and benefits to the extent of the Office services provided.

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

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

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

I consent to treatment necessary or desirable to the care of the patient first mentioned above, including, but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, X-Ray, or other studies that may be used by the attending doctor, his nurse, or qualified designate. I also acknowledge full responsibility for the payment of such services, and agree to pay for them at the time of service. I understand that the charges made for professional services may not be covered in full by insurance although insurance may be filed. I understand that the patient or the responsible party is solely responsible for the payment of all services. If the account becomes delinquent in payment I agree to pay all cost of collection, including a reasonable attorney's fee.

_____
Print Patient's Name

_____ Date:_____/_____/_____
Signature of Patient

Social Security #:_____/_____/_____

**Alabama Chiropractic Spine & Joint**
Dr. Bailey Carroll DC

(256)284-7179
100 Pinebrook Dr.
Florence, AL 35633

# Authorization for Release of Medical Records

Patient Name:_____ Date:_____

Date of Birth:_____ Social Security Number:_____-____-_____

Information Released to: Alabama Chiropractic Spine & Joint Clinic
100 Pinebrook Dr.
Florence, AL 35633
Fax Number: 256-284-7187

Information Requested : _____
_____
_____
_____
_____
_____

I HEARBY AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL INFOTMATION, TO INCLUDE ALL PHYSICIAN'S NOTES, LAB RESULTS, X-RAY AND IMAGING RESULTS ALSO INCLUDING DIAGNOSIS, TREATMENT, PROGNOSES, ETC..., OF THE INJURIES AND/OR ILLNESS RECEIVED BY THE ABOVE NAMED PERSON ON THE SUBSEQUENT DATE OF THE INJURIES AND/OR ILLNESSES. AUTHORIZATION EXPIRES IN 365 DAYS UNLESS REVOKED IN WRITING.

Patient Signature:_____ Date:_____

Witness:_____ Date:_____

**Alabama Chiropractic Spine & Joint**
**Dr. Bailey Carroll DC**

**(256)284-7179**
**100 Pinebrook Dr.**
**Florence, AL 35633**

# Notice of Privacy Practices

Attached you will find a copy of our office Privacy policies and practices. We invite you to read these policies and keep all but this sheet for your reference.

Please read the attached sheet and sign below acknowledging that you understand the policies. If you have any questions regarding the information presented herein, feel free to ask us here in the office or contact us by phone at anytime.

Date: _____

Name of Patient (print): _____

Signature of Patient: _____

Signature of Guardian: _____

Witness: _____

ALABAMA CHIROPRACTIC
SPINE & JOINT CLINIC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS TO THIS INFORMATION. *PLEASE REVIEW CAREFULLY.*

Alabama Chiropractic Spine & Joint Clinic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

**Discloser of Your Health Care Information**

**Treatment:** We may disclose your health care information to other healthcare professional within out practice for the purpose of treatment, payment or healthcare operations. (Example)

*"On occasion, it may be necessary to seek consultation regarding your condition from other heath care providers associated with Alabama Chiropractic Spine & Joint Clinic."*

*"It is our policy to provide a substitute health care provider, authorized by Alabama Chiropractic Spine & Joint Clinic to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

**Payment**: We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

**Workers' Compensation**: We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

**Emergencies:** We may disclose your health information to notify or assist in notifying a family member, or another person responsible for you care about your medical condition or in the event of an emergency or of your death.

**Public Health:** As required by law, we may disclose your health information to public health authorities for purpose related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

**Judicial & Administrative Proceedings:** We may disclose your health information in the course of any administrative or judicial proceeding.

**Law Enforcement:** We may disclose your health information to a law enforcement official for purpose such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purpose.

**Deceased Person:** We may disclose your health information to coroners or medical examiners.

**Organ Donation**: We may disclose your health information to organizations involved in procuring, banking, or transplant organs and tissues.

**Research:** We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

**Public Safety**: It may be necessary to disclose your health information to appropriate persons in order to prevent or lesson a serious and imminent threat to the health or safety of a particular person or to the public.

**Specialized Government Agencies**: We may disclose your health information for military, national security, prisoners and government benefits purposes.

**Change of Ownership:** In the event that Alabama Chiropractic Spine & Joint Clinic is sold or merged with another organization, your health information/record will become the property of the new owner.

**Your Health Information Rights:**

~You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however , that Alabama Chiropractic Spine & Joint Clinic is not required to agree to the restriction that you requested.

~You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

~You have the right to inspect and copy your health information.

~Your have a right to request that Alabama Chiropractic Spine & Joint Clinic amend your protected health information. Please be advised, however, that Alabama Chiropractic Spine & Joint Clinic is not required to agree to amend your protected health information. If your request to amend your health information had been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

~You have a right to receive an accounting discloser of your protected health information made by Alabama Chiropractic Spine & Joint Clinic.

~You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

**Changes to this Notice of Privacy Practice:**

~ Alabama Chiropractic Spine & Joint Clinic reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendments is made, Alabama Chiropractic Spine & Joint Clinic is required by law to comply with this notice.

~ Alabama Chiropractic Spine & Joint Clinic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Dr. Bailey Carroll by calling this office at 256.284.7179. If Dr. Bailey Carroll is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

**Complaints:** Complaints about your Privacy rights, or how Alabama Chiropractic Spine & Joint Clinic has handled your health information should be directed to Dr. Bailey Carroll by calling this office at 256-284-7179. If Dr. Bailey Carroll is not available, you make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaints, you may submit a formal complaint to DHHS, Office of Civil Rights

200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

# THIS IS YOUR COPY TO KEEP