COMMONWEALTH CHIROPRACTIC CENTER
Dr. CR Chip Salyers II BS CCSP DC
1827 Ky Route 321
Prestonsburg, Ky 41653
Ph. 606-889-9222 Fax. 606-886-1605

Name_____SS#_____

Height_____ Weight_____ Race_____ Date of Birth_____ Age_____

Smoker Y or N If YES, Everyday, Sometimes or Former Smoker

Address_____City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____

Sex M F Marital Status: Married Single Divorced Widowed Legally Separated

Spouses Name_____

Occupation/Employer_____

Referred by: _____

In case of Emergency, Contact_____

Have you ever received Chiropractic Care? Yes No If yes, Name of Doctor and when? _____

1. **Reasons for seeking chiropractic care:**
   Major Complaint: How Long:
   _____

2. **Previous interventions, treatments or Doctors care you have sought for your complaint(s):**
   _____
   _____
   _____

   Are your symptoms related to an accident or injury Y or N If Yes, Explain_____
   _____

   During the accident were you in the course of your employment Y or N
   If your symptoms already existed, were they made worse by the accident Y or N
   Were symptoms Dormant before this accident Y or N

   Name/address of your Medical Doctor_____

3. **Past Health History:**

   A. Please indicate if YOU have a history of any of the following:
   □ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
   □ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
   □ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other _____
   □ None of the above

   B. Previous Injury/Trauma/Auto accidents or Severe falls:
   _____
   _____
   _____

Have you ever broken any bones? Which?

_____

C. Allergies: _____

D: Medications:

Medication	**Reason for taking**

E. Surgeries:

Date	**Type of Surgery**

3. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

Family History:

Mother:	**____Alive/Well**	**____Deceased**
Father:	**____Alive/Well**	**____Deceased**
Brothers (put the number of, in each choice):	**____Alive/Well**	**____Deceased**
Sisters (put the number of, in each choice):	**____Alive/Well**	**____Deceased**
Children (put the number of, in each choice):	**____Alive/Well**	**____Deceased**

Social and Occupational History:

A. Recreational activities:

_____

_____

B. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

_____

Review of Systems:

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Have you had any of the following **Gynecology** issues? **(FEMALES)**
□ Abnormal periods □ Currently pregnant □ Miscarriages □ Ovarian cancer □ Polycystic disease □ Fibrocystic disease
□ Abnormal pap smear □ Abnormal mammogram □ Infertility □ Other_____ □ None of the above

Have you had any of the following **Urology** issues? **(MALES)**
□ Low testosterone □ Prostate cancer □ Incontinence □ Enlarged prostate □ Other_____ □ None of the above

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Commonwealth Chiropractic Center for services performed. Patient or

Signature _____

Date_____

HIPAA 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.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Signature of Patient of Representative Date

_____

Printed Name

If you would like to have a copy of the Notice of Privacy Practices for your own records, please request one at the registration desk.

NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

Symptom 4_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

Symptom 5 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

Symptom 6 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Did the symptom begin suddenly or gradually? (circle one)
    - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

MEDICAL HISTORY

HAVE YOU EVER HAD A HISTORY OF OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING (CHECK BELOW)

YES	NO		IF YES EXPLAIN
_____	_____	**EPILEPSY/SEIZURES**	_____
_____	_____	**ANEURYSM**	_____
_____	_____	**CHEST PAIN**	_____
_____	_____	**HEART ATTACK**	_____
_____	_____	**STROKE/TIA**	_____
_____	_____	**HIGH BLOOD PRESSURE**	_____
_____	_____	**BLOOD CLOTS**	_____
_____	_____	**HEART MURMUR/VALVE DISEASE**	_____
_____	_____	**IRREGULAR HEARTBEAT**	_____
_____	_____	**CONGESTIVE HEART FAILURE**	_____
_____	_____	**ARTIFICIAL JOINTS OR HEART VALVES**	_____
_____	_____	**INTERNAL PACEMAKER OR DEFIBRILLATOR**	_____
_____	_____	**BRAIN STIMULATOR**	_____
_____	_____	**CANCER (IF SO, WHAT KIND)**	_____
_____	_____	**SKIN CANCER/MELANOMA**	_____
_____	_____	**BROKEN/IRRITATED SKIN**	_____
_____	_____	**MIGRAINE HEADACHES/OTHER HEADACHES**	_____
_____	_____	**ANEMIA**	_____
_____	_____	**EXCESSIVE SCARRING OR BLEEDING**	_____
_____	_____	**VISUAL PROBLEMS/EYE DISEASE**	_____
_____	_____	**ARTHRITIS**	_____
_____	_____	**GOUT**	
_____	_____	**DIABETES**	_____
_____	_____	**BREAST DISEASE**	_____
_____	_____	**LIVER PROBLEMS/HEPATITS/JAUNDICE**	_____
_____	_____	**KIDNEY/BLADDER PROBLEMS**	_____
_____	_____	**LUNG DISEASE/RESPIRATORY PROBLEMS/TB**	_____
_____	_____	**GALLBLADDER PROBLEMS**	_____
_____	_____	**STOMACH/BOWEL PROBLEMS**	_____
_____	_____	**ASTHMA/HAY FEVER/ECZEMA**	_____
_____	_____	**DEPRESSION/MENTAL ILLNESS**	_____
_____	_____	**BLOOD TRANSFUSIONS**	_____
_____	_____	**HIV DISEASE, AIDS**	_____
_____	_____	**BREAST AUGMENTATION**	_____
_____	_____	**ALLERGIES**	_____
_____	_____	**HYPOTHYROIDISM**	_____
_____	_____	**OTHER DISEASES**	_____
_____	_____	**METALLIC IMPLANTS**	_____
_____	_____	**NEURO STIMULATOR**	_____
_____	_____	**STENT,SHUNT, PAIN PUMP**	_____
_____	_____	**SHRAPNEL**	_____
_____	_____	**CLAUSTRAPHOBIC**	

Have you recently had a CT/MRI within the last year? YES or NO if yes where? _____
Are you currently taking Ibuprofen/Motrin? YES or NO if yes How long, and milligram_____
Have you had Physical Therapy within the last year? If so, how long and where?_____

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Dr. C.R. Salyers, II BS DC

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606-889-9220

Fax: 606-886-1605

INFORMED CONSENT

PATIENT'S NAME_____

Dear Patient:

State law requires us to obtain your informed consent prior to examination and treatment. The purpose of this form is to inform you, not to alarm you. What you are being asked to sign is simply a confirmation that we have discussed the following:

ASSOCIATES AND ASSISTANTS
In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, and treatment.

EXAMINATIONS
X-ray: Concerning x-ray examination, this office uses highly sensitive screens that provide the highest quality with the least exposure. This is important since certain conditions will call for the retaking of certain x-rays when circumstances warrant.

The only noteworthy inherent risk with taking x-rays, deals with pregnancy. **If there is a possibility that you are pregnant, inform this office prior to x-ray examination.** If there is no possibility of this condition, the inherent risks are so rare that I have no available statistics to quantify their probability.

TREATMENT
The Chiropractic Adjustment: I will use my hands or a mechanical device upon your body in such a way as to move your joints. This procedure may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. There are some material risks involved in doing this and they are as follows:

INHERENT RISKS
Pain: It is common for an adjustment as well as traction, massage therapy, exercise, in fact almost any treatment, to result in a temporary increase in soreness in the region being treated.

Rib Fractures: The force of an adjustment might "crack" a rib. This can happen with anyone; however it occurs most often on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays and when detected, we proceed with extra caution. These problems occur so rarely that I haven't been able to find available statistics to quantify their probability.

Disc Herniation: Occasionally treatment will aggravate or cause a problem if the disc is in a weaken state. It is possible that surgery may become necessary for correction, but again these problems occur so rarely that I haven't been able to find available statistics to quantify their probability.

Stroke: Even though strokes happen with some frequency in our world, strokes resulting from a chiropractic adjustment are rare. So rare that you have the same chance of getting hit by lightening; one in a million. In fact, according to the Journal of the Canada Chiropractic Association Vol. 37, No. 2 June, 1993, the risk of a stroke from chiropractic is one per every three million upper neck adjustments. Even though the risk of stroke in this office is small, we have implemented procedures, and tests that reduce your risk of stroke even more.

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The type of adjustment related to vertebral artery stoke is called the extension-rotation-thrust atlas adjustment. This type of adjustment is not done in this office. Our patients are also given certain tests that warn of certain conditions more susceptible to stroke, thus reducing your risk even more.

Physical Therapy Burns: Some of the machines we use generate heat. We also use ice in the office. Since everyone's skin has different sensitivity to these modalities, we test our patients for sensitivity deficiencies prior to therapy use. If a burn is obtained, there will be a temporary pain and possible blistering. This should be reported to the doctor. This is so rare that I haven't found any statistics to quantify its probability.

Other Problems: There may be other problems or complications that might arise from treatment, such as massage, traction, etc., than noted above. These other problems or complications occur so rarely that it is not plausible to anticipate and/or explain them all in advances of treatment.

NON TREATMENT
Remaining untreated results in adhesions, pain and, reduction in associated joint mobility which. The probability that these adhesions will interfere with the motion, function, and enjoyment of life is very high.

OTHER PROBLEMS
There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery. As with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

I hereby authorize and direct the above named doctor with assistants to provide such additional services as they may deem reasonable and necessary.

I hereby state that I have read or have had read to me this consent form, and all blanks were filled in prior to my signature.

DATE: _____ TIME: _____ A.M. P.M.

Patient's Printed Name: _____

Patient's Signature: _____

Signature of Guardian: _____

Witness' Printed Name: _____

Witness' Signature: _____

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AUTHORIZATION, ASSIGNMENT, AND RELEASE FORM

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me of you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company(the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fir and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Kentucky.
5. I further agree that this Authorization and Assignment is irrevocable an ongoing until all monies owed are paid in full.
6. This Authorization for Assignment will be in continual effect until revoked by both parties.

_____ **X**_____

DATE **PATIENT/INSURED SIGNATURE**

RECORDS RELEASE

To_____, I hereby authorize you to release to **Dr. Charles R. "Chip" Salyers II** any information including the diagnosis and records of treatment or examination rendered to me for all care during the period from _____ thru _____.

_____ **X**_____

DATE **PATIENT/INSURED SIGNATURE**

Consent to wireless telephone calls: if at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify this facility to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from this office, or affiliates, contractors, servicers, attorneys or its agents including collection agencies. **Consent to email usage**: If at anytime I provide my email address at which I may be contacted, unless I notify this facility to the contrary in writing, I consent to receiving communications,regarding billing and payment for items and services at that email address from this facility, affiliates, contractors, servicers, attorneys, or its agents, including collection agencys.

_____ **X**_____

DATE **PATIENT/INSURED SIGNATURE**

COMMONWEALTH CHIROPRACTIC CENTER, PSC
1827 Ky Route 321
Prestonsburg, Ky 41653
606-889-9222

Consent to use PHI

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Commonwealth Chiropractic Center, PSC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.
I have received a copy of the Notice of Patient Privacy Policy. _____ Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

PLEASE CIRCLE ONE

YES or NO I, hereby give Dr. Charles R. "Chip" Salyers II and/or his staff at Commonwealth Chiropractic Center, consent to give to my spouse or other family member any information pertaining to me (medical or financial). I also understand that at some point, if I change my mind, or divorce, it is my responsibility to inform this office of such changes pertaining to my medical records and finances.

By my signature below I give my permission to use and disclose my health information.

X _____ _____
Patient or Legally Authorized Individual Signature — Date

X _____ _____
Print Patient's Full Name

_____ _____
Witness Signature — Date