

# Dothan Chiropractic Clinic, P.C.

Paul D. Weeks, D.C.

Telephone: 334-793-1081

Fax: 334-792-7600

## AUTHORIZED PATIENT NOTIFICATION LIST

(Required of HIPAA) Health Insurance Portability and Accountability)

I, \_\_\_\_\_, authorize all Dothan Chiropractic Clinic Physicians and/or whomsoever he/she may designate as his/her professional representative/assistant to discuss any aspect of my chiropractic care, to include: appointments, tests, test results, surgical procedures, and any other pertinent information pertaining to my care with the following designated people:

_____	_____
_____	_____
_____	_____

This document will be a part of your permanent record. In the event that any of the selected representatives that you designated change, it will be necessary to update our records with a written notification. You will need to state who you would like to have removed from or added to the Authorization Notification List.

\_\_\_\_\_  
PATIENT/OTHER PERSON AUTHORIZED TO SIGN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
RELATION TO ABOVE SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE

\_\_\_\_\_  
DATE

**Dothan Chiropractic Clinic, P.C.**

**Financial Policy**

Thank you for choosing Dothan Chiropractic Clinic, P.C. to provide you with service. Please understand that payment of your bill is considered a part of your treatment. As part of your treatment, you must complete a patient information sheet and present the required insurance information before seeing the physician. Please inform us of any changes in this information.

The following are requirements for payment of medical services:

**Regarding Fee for Service Patients...**

We require payment in full for services to patients with no insurance. Payment may be made by cash, check, money order, or major credit card. If this is not possible we are willing to enter into a financial arrangement regarding your balance.

**Regarding Financial Arrangements...**

We understand that sometimes medical costs can be high and the funds are not readily available and payment arrangements are needed. It is our policy that these arrangements are made prior to services being performed. It is understood that the patient must meet any payment plan that is agreed upon timely or risk the possibility of being placed with a collection firm.

**Regarding Insurance...**

We will accept assignment of benefits from your primary insurance and one other insurance. A copy of your insurance card(s) is required by our office and any changes must be brought to the attention of our office.

If your policy has deductible or patient responsibility co-pay, you are required to make payment prior to treatment unless prior arrangements have been made with our insurance department.

Thank you for taking the time to read our Financial Policy. Should you not make satisfactory financial arrangements your account will be forwarded to our collection agency. Once the account is placed with our collection agency you will agree to the following terms:

Regarding any outstanding balance that I owe: (1) I will incur interest at the rate of 1 & 1/2 percent per month (18% PER ANNUM); (2) I will be responsible for reasonable collection costs, reasonable attorney's fees and cost of court incurred by Dothan Chiropractic Clinic, P.C. in the collection of same; and (3) Any lawsuit and/or legal proceeding surrounding the outstanding balance and debt shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and/or objections to said jurisdiction. By signing below, I consent to the terms contained herein and affirmatively acknowledge that I have read the same before signing.

**I have read, understand and agree to this Financial Policy.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

**DOTHAN CHIROPRACTIC CLINIC, P.C.  
PAUL D. WEEKS, D.C.**

**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 **Dothan Chiropractic Clinic, P.C., P O Box 986, Dothan, AL 36302, F.I.D. 63-1164147** such sums as may be due and owing this Office for services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, health and accident benefits, workmen's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as maybe necessary to adequately protect said Office. I hereby further give a lien to said Office against any and 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 act as an assignment of my rights and benefits to the extent of the Office's 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 on demand by me or this Office, I hereby assign and transfer to this Office any and all causes 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 claims or cause of action as they see fit.

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

I authorize the 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 power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

DATE \_\_\_\_\_

SIGNED \_\_\_\_\_

# Dothan Chiropractic Clinic, P.C.

Paul D. Weeks, D.C.

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## HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you may get access to this information. Please review it carefully.

Dothan Chiropractic Clinic, P.C. is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Dothan Chiropractic Clinic, P.C. is required by law to abide by the terms of this Notice.

### How your medical information will be used and disclosed:

We will use your medical information as part of rendering patient care. For example, the doctor or nurse treating you, by the business office to process your payment for the services rendered and by administrative personnel reviewing the quality of the care you receive may use your medical information.

We may also use and/or disclose your information in accordance with federal and state law without your consent for the following purposes:

- \* Appointment Reminders - May contact you to provide appointment reminders.
- \* Treatment Information - Other alternative treatments or health-related services that may be of interest to you.
- \* Law Enforcement - May disclose your information as required during an investigation.
- \* Legal Proceedings - May disclose your information in the course of certain judicial or administrative proceedings.
- \* Public Safety - May disclose your information to prevent or lessen serious threat to the health or safety to the public.
- \* Military Activity and National Security - May disclose information to military command for their military records or other federal officials conducting national security and intelligence activities for protective services for the President.
- \* Worker's Compensation - May disclose information as authorized to worker's compensation or similar programs.
- \* Inmates - May disclose information to the correctional facility or law enforcement official for your proper care.
- \* Abuse and Neglect - May disclose information when it concerns abuse, neglect or violence in accordance to federal or state law.
- \* Food and Drug Administration - May disclose information to report adverse events, product recalls, to make repairs or replacements.
- \* Research - May disclose information for certain research purposes if an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your information.
- \* Disclosure to Department of Health and Human Services - May disclose information for public health purposes to help control disease, injury, or disability, also to a person who may have been exposed to a communicable disease or at risk of contacting or spreading a disease or condition.
- \* Others Involved in Your Healthcare - May disclose information to a family member, other relatives, close personal friends or other representative you authorize when medical information is directly relevant to that person's involvement in your care.
- \* Health Oversight Activities - May disclose information for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee health care systems, government benefit programs, and other government regulatory programs and civil rights law.
- \* Disaster Relief - May disclose information to a public entity, such as the American Red Cross, for purpose of coordinating with that entity to assist in disaster relief efforts.
- \* Business Associates - May disclose information to a business associate that we have a contract with to provide services on our behalf. We require our business associates to appropriately safeguard the health information of our patients.

### AUTHORIZATIONS:

We will not use or disclose your medical information for any purpose without your written authorization. Once given, you may revoke your authorization in writing at any time.

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## HIPAA NOTICE OF PRIVACY PRACTICES

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

### Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to a report of disclosures of your information.
6. The right to a paper copy of this Notice.
7. The right to file a complaint if you feel your privacy has been violated.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

### Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of Dothan Chiropractic Clinic, P.C.'s **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights, that I may contact the person named as Privacy Officer. I further understand that Dothan Chiropractic Clinic, P.C. will offer me updates to this **NOTICE OF PRIVACY PRACTICES**, should it be amended, modified or changed in any way.

---

Patient or Representative Name (Please Print)

\_\_\_\_\_  
Patient or Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_ Patient refused to sign

\_\_\_\_ Patient was unable to sign because-

Documented by \_\_\_\_\_

## **PREGNANCY WAIVER**

I hereby acknowledge that Dr. Paul D. Weeks of the Dothan Chiropractic Clinic, P.C. has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own violation that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient/Authorized Representative of Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Office Use Only**

- 1
- 4-5
- >5

Patient #: \_\_\_\_\_

## Pain Drawing

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Examiner: \_\_\_\_\_

### TELL US WHERE YOU HURT.

*Please read carefully:*

*Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.*

Ache >>>>>

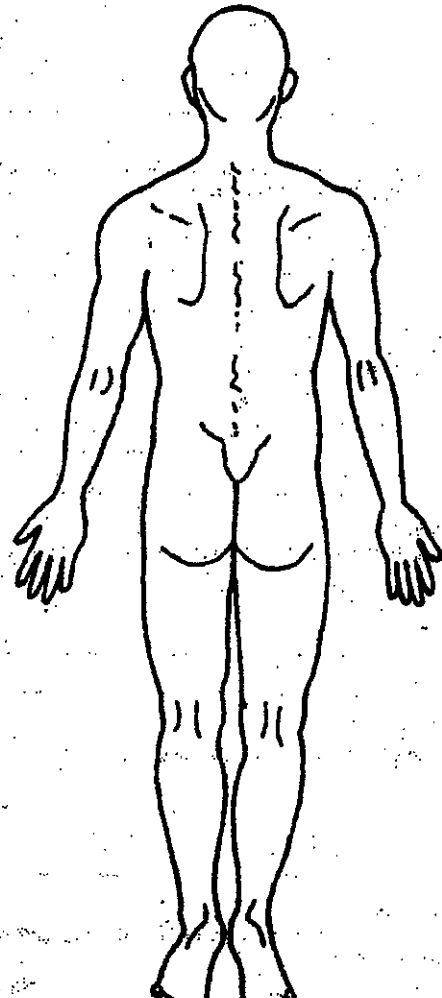
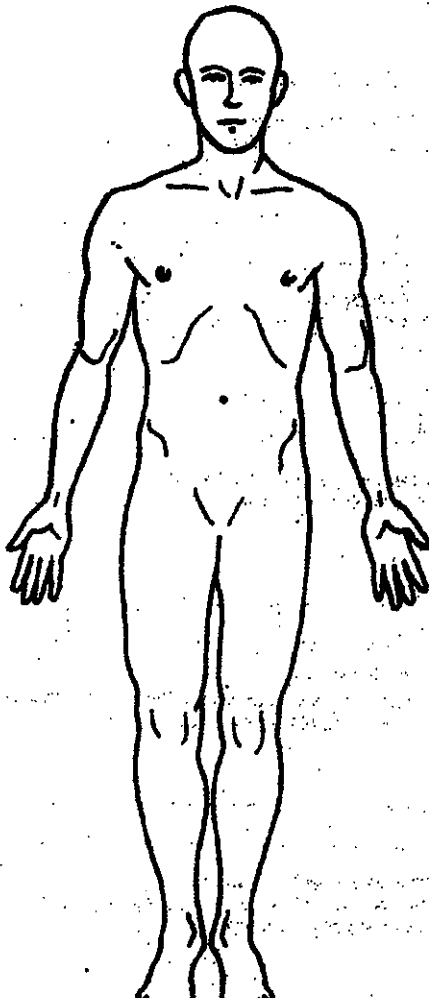
Burning x x x x

Numbness =====

Stabbing /////

Pins & Needles o o o o

Throbbing ~~~~~



# Dothan Chiropractic Clinic, P.C.

Paul D. Weeks, D.C.  
441 South Oates Street  
Dothan, Alabama 36301  
F.I.D. #631164147

## CONFIDENTIAL PATIENT INFORMATION

Date \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital: M S W D Sex: F M HOW MANY CHILDREN \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Office Phone \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Spouse Birth Date \_\_\_\_\_ Spouse S.S. # \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Office Phone \_\_\_\_\_

Patient's Nearest Relative \_\_\_\_\_ Phone \_\_\_\_\_

Referred By: \_\_\_\_\_

Date of Last Physical Examination \_\_\_\_\_

What Operations Have You Had? \_\_\_\_\_ When? \_\_\_\_\_

Serious Illnesses? \_\_\_\_\_ When? \_\_\_\_\_

Have You Ever Suffered From:

1. Dizziness: \_\_\_\_\_

2. Backaches: \_\_\_\_\_

3. Heart Trouble: \_\_\_\_\_

4. Diabetes: \_\_\_\_\_

5. Tuberculosis: \_\_\_\_\_

6. Arthritis: \_\_\_\_\_

7. Headaches: \_\_\_\_\_

8. Numbness: \_\_\_\_\_

9. Asthma: \_\_\_\_\_

10. Neuritis: \_\_\_\_\_

11. Digestive Disorders: \_\_\_\_\_

12. Nervousness: \_\_\_\_\_

13. Sinus Trouble: \_\_\_\_\_

14. Anemia: \_\_\_\_\_

15. Rheumatic Fever: \_\_\_\_\_

16. Cancer \_\_\_\_\_

Purpose of  
This Appointment: \_\_\_\_\_

Other Doctors Seen For This Condition \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year? YES  NO

Describe \_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_

### IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE INFORMATION REQUESTED ON THE REVERSE SIDE

Remarks and additional information \_\_\_\_\_

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment \_\_\_\_\_

ARE YOU INSURED?  YES  NO COMPANY \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that DOTHAN CHIROPRACTIC CLINIC, P.C. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to DOTHAN CHIROPRACTIC CLINIC, P.C. will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature \_\_\_\_\_ SS # \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse's  
Signature Authorizing Care: \_\_\_\_\_ SS # \_\_\_\_\_ Date \_\_\_\_\_

Information Taken By: \_\_\_\_\_ Date: \_\_\_\_\_

NAME \_\_\_\_\_

**IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE  
THE FOLLOWING QUESTIONS**

Date of Accident: \_\_\_\_\_ Hour \_\_\_\_\_ AM \_\_\_\_\_ PM Location \_\_\_\_\_

How Did Accident Occur?  Auto Collision  On-the-job Injury  Other

If Not An Auto Collision, Please Describe The Circumstances \_\_\_\_\_

Did You Report The Injury To Your Foreman or Employer?  YES  NO

Did He (They) Recommend Care At Our Office?  YES  NO

If Auto Accident, Were You Driver  Passenger  Pedestrian

If Auto Collision, Were You Struck From Behind  Right Side  Left Side  Front  Auto Was Parked

Did Your Car Strike The Other(s) Involved  YES  NO; Or Did The Other Car Strike Yours?  YES  NO  Undetermined

As a Result of The Accident Were Traffic Citations Issued To You  YES  NO; To The Driver of The Other Car  YES  NO;  
To The Driver of Your Car  YES  NO

List The Extent of The Injuries As You Know Them \_\_\_\_\_

Did You Require Post-Accident Hospitalization?  YES  NO

**CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:**

- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Numbness in Toes    | <input type="checkbox"/> Face Flushed    | <input type="checkbox"/> Feet Cold     |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold    |
| <input type="checkbox"/> Neck Stiff        | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems Too Heavy   | <input type="checkbox"/> Depression          | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes  | <input type="checkbox"/> Loss of Smell   | <input type="checkbox"/> Cold Sweats   |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory      | <input type="checkbox"/> Loss of Taste   | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Ears Ring           | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> _____         |

Symptoms Other Than Above \_\_\_\_\_

Have You Lost Any Days of Work? \_\_\_\_\_ Dates: \_\_\_\_\_

Insurance Companies Involved:

My Company \_\_\_\_\_

Company of Person Responsible For Injuries \_\_\_\_\_

Have You Been Contacted By an Insurance Adjuster or Company Representative Regarding This Claim  YES  NO

Do You Have An Attorney That Has Advised You In This Case?  YES  NO

Name \_\_\_\_\_ Address \_\_\_\_\_ Telephone \_\_\_\_\_