NORTHERN CHIROPRACTIC, P.C.

PERSONAL

Thank You For Choosing Us As Your Option For Health

First Name _____ MI ____ Last _____

Nickname _____

Address _____

City _____ State _____ Zip _____

Social Security# _____

Gender ❑ Male ❑ Female Birth Date _____ Age _____

Cell # _____

Secondary Contact # _____ work / cell / hm

May we text appt. reminders? Y N Phone _____

Email _____

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Spouse _____

Emergency Contact _____

Relation to Contact _____ Phone _____

Whom may we thank for referring you to us?

How did you choose our clinic?

❑ Echo Magazine
❑ Good Deal Magazine
❑ Office Sign
❑ Website
❑ Yelp
❑ Google
❑ Insurance PPO _____
❑ Location
❑ Health Care Provider/Doctor
❑ Other

CASE

Were you in an Auto Accident? _____ Injury Date: _____

Were you in a Work related Injury? _____ Injury Date: _____

Will you be utilizing medical benefits? _____

NO Insurance	**Medicaid**	**Auto Med-Pay**	
Insurance	**Medicare**	**Work Comp Ins.**	

Occupation _____

Employer _____

Address _____

Department _____

City _____ State _____ Zip _____

Phone _____

Fax _____

PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED

PAYMENT METHOD FOR PATIENT'S PORTION WILL BE:

❑ Cash ❑ Check ❑ Credit Card
❑ Check Debit ❑ Credit Balance

GUARANTOR

Policy Holder (PH) _____

Address _____

City _____ State _____ Zip _____

Social Security# _____

Gender ❑ Male ❑ Female Birth Date _____ Age _____

Home Phone _____

Employer (PH) _____

Employer Phone _____

Address _____

City _____ State _____ Zip _____

Insurance _____

Call Benefits @ _____

Contact _____

Group Number _____

ID/Claim # _____

2nd Insurance

Patient Is:

❑ Self ❑ Spouse ❑ Child ❑ 3rd Party ❑ Other _____

CONSENT TO TREAT MINOR

I authorize Dr. Gregory Culbert to perform chiropractic care on my child _____

X _____ _____
Parent/Guardian's Signature Date

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I authorize the release of any medical information necessary to process and pay this claim. I authorize payment directly to:

NORTHERN CHIROPRACTIC

of the "Health Benefits", "Medical Reimbursement" from a Third Party Payor and/or "Government Benefits" otherwise payable to me. I understand this office only accepts assignment when insurance pays directly.

X _____ _____
Patient/Guarantor's Signature Date

GENTLE, EFFECTIVE HEALTHCARE FOR ALL AGES AND LIFESTYLES

Gregory M. Culbert, D.C. DABCO, Chiropractic Orthopedist
11723 Old Glenn Highway • Eagle River, AK 99577 • Phone (907) 696-4878 • Fax (907) 696-4674

PAST HEALTH HISTORY

Fractured/Broken Bones? When? Where? _____

_____

Major Accidents or Falls? When? _____

_____

Prior Surgeries? When? _____

_____

Medications/Vitamins? Today? _____

Prior Diagnosis/Disease/Illness? When? _____

Allergies? _____

Habits? _____

Medical doctor's name: _____

Are you under a doctor's care now? Why? _____

Is this your first visit to a Chiropractor? Yes No

Name/Address of former Chiropractor: _____

(Women) Are you pregnant or trying? Yes No Nursing? Yes No Taking birth control pills? Yes No

EXERCISE AND WORK

What type of exercise do you perform on a regular basis? _____

What do your daily work habits include? (sitting, standing, light labor, heavy labor, computer work): _____

_____

FAMILY HISTORY

Has any member of your family had any of the following? List Relationship Arthritis? Type? _____

High Blood Pressure? _____ Diabetes? _____ Cancer? Type? _____

Heart Problems? _____ Back or Neck Problems? _____ Other? _____

PRESENT HEALTH HISTORY

Purpose of this chiropractic appointment: ❑ Examination ❑ Emergency ❑ Consultation

Date and time of injury: _____ Location of injury: _____

What activity were you doing when injured? _____

When did you first notice the symptoms? _____ Symptoms developed from: _____

_____

Were you hospitalized? Yes No Where? _____

Major complaints: _____

_____

Have you had this complaint before? Explain: _____

_____

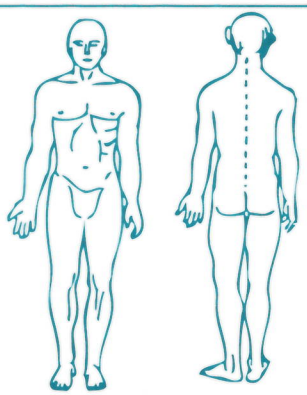
Doctors seen for this ailment: _____

Type of Doctor: _____ Diagnosis: _____

Treatment: _____ Results: _____

Label area(s) of discomfort using arrows and other descriptions as needed:

Pain: XXX
Numb: NNN
Burn: BBB
Spasm: SSS
Tingly: TTT



Comments/descriptions: _____

_____

_____

_____

_____

_____

_____

_____

_____

WORKERS' COMPENSATION

Activity performed at the time of injury: _____

_____

_____

Further describe accident: _____

_____

_____

Describe your job (daily activities, responsibilities, posture—i.e. sitting, standing, etc.): _____

_____

_____

Is lifting involved? Yes___ No___ If yes, list weight and frequency: _____

_____

Are you put in awkward lifting positions? Explain: _____

_____

Are repetitive movements of the hands/fingers a part of your job? Explain: _____

_____

Have you ever been injured in this hurt area before? If yes, explain: _____

_____

_____

Have you seen other doctors for this particular occurrence? If so, Who/When: _____

_____

_____

Have you reported this injury to your employer/supervisor? Yes__ No__

Name of your employer/supervisor: _____

Have you lost any time from work because of this injury? Yes__ No__ If yes, list dates: _____

_____

Who is your workers' compensation carrier? _____

Have you retained an attorney for this case? Yes__ No__ If yes, list Name/Address/Phone: ____

_____

_____

Please give front desk a copy of "Report of Accident" form from your employer

Oswestry Low Back Pain Scale

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, ect.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal sleep is reduced by less than one-quarter.
3. Because of my pain my normal sleep is reduced by less than one-half.
4. Because of my pain my normal sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 - Traveling
0. I get no pain when traveling
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels me to seek alternate forms of travel.
4. Pain restricts me to travel short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____

Neck Disability Index

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. I have no pain at the moment.
1. The pain is mild at the moment.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain is severe but comes and goes.
5. The pain is severe and does not vary much.

Section 2 – Personal Care
0. I can look after myself without causing extra pain.
1. I can look after myself but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help, but manage most of my personal care.
4. I need help every day in most aspects of self-care.
5. I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it causes extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

Section 4 – Reading
0. I can read as much as I want to with no pain in my neck.
1. I can read as much as I want with slight pain in my neck.
2. I can read as much as I want with moderate neck pain.
3. I cannot read as much as I want because of moderate pain in my neck.
4. I cannot read as much as I want because of severe pain in my neck.
5. I cannot read at all.

Section 5 – Headache
0. I have no headaches at all.
1. I have slight headaches which come infrequently.
2. I have moderate headaches which come infrequently.
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently.
5. I have headaches almost all the time.

Section 6 - Concentration
0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate fully when I want to with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

Section 7 – Work
0. I can do as much work as I want to.
1. I can only do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

Section 8 – Driving
0. I can drive my car without neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate pain in my neck.
3. I cannot drive my car as long as I want because of moderate pain in my neck.
4. I can hardly drive my car at all because of severe pain in my neck.
5. I cannot drive my car at all.

Section 9 – Sleeping
0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation
0. I am able to engage in all recreational activities with no pain in my neck.
1. I am able to engage in all recreational activities with some pain in my neck.
2. I am able to engage in most, but not all, recreational activities because of pain in my neck.
3. I am able to engage in a few of my usual recreational activities because of pain in my neck.
4. I can hardly do any recreational activities due to pain in my neck.
5. I cannot do any recreational activities at all.

TOTAL _____

Daily Living Limitations

Name_____ Date_____

- **Activities of Daily Living** (How does this condition currently interfere with your life and ability to function?)

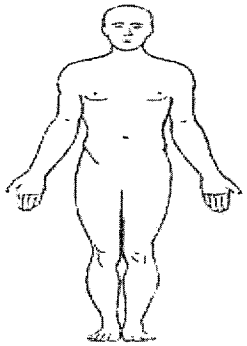
	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	O	O	O	O
Rising out of chair	O	O	O	O
Standing	O	O	O	O
Walking	O	O	O	O
Lying Down	O	O	O	O
Bending over	O	O	O	O
Climbing stairs	O	O	O	O
Using a computer	O	O	O	O
Getting in/out of car	O	O	O	O
Driving car	O	O	O	O
Looking over shoulder	O	O	O	O
Caring for family	O	O	O	O

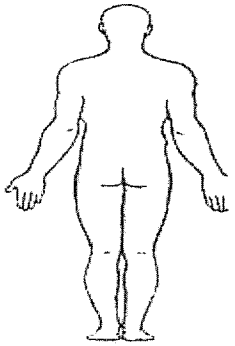
	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	O	O	O	O
Household chores	O	O	O	O
Lifting objects	O	O	O	O
Reaching Overhead	O	O	O	O
Showering or bathing	O	O	O	O
Dressing myself	O	O	O	O
Yard work	O	O	O	O
Getting sleep	O	O	O	O
Staying asleep	O	O	O	O
Concentrating	O	O	O	O
Exercising	O	O	O	O

~~What percentage do you feel your pain has improved since your last evaluation?~~ _____

Label area(s) of discomfort using arrows, and other descriptions as needed:

Pain	**XXX**
Numb	**NNN**
Burn	**BBB**
Tingly	**TTT**





Comments/Descriptions_____

PHYSICIAN'S REPORT

ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT
Alaska Workers' Compensation Board
P.O. Box 115512, Juneau AK 99811-5512

◯ **INITIAL** Employee: Sections 1 & 2/Physician: Sections 3 & 4
◯ **PROGRESS** Physician: Sections 1 & 4
◯ **TREATMENT PLAN** Employee: Sections 1 & 2/ Physician: Sections 3 & 4

AWCB Case Number:

SECTION 1

1. Employee's Name (Last, First, Middle Initial)				2. Insurer Claim Number	3. Date of Injury
4. Address				5. Sex ◯ Male ◯ Female	6. Social Security Number
City	State	Zip Code	Telephone		7. Date of Birth
8. Employer				9. Insurer	
10. Address				11. Address	
City	State	Zip Code	Telephone	City State Zip Code Telephone	

SECTION 2

12. Date Last Worked	13. Was Body Part Injured Before? ◯ No ◯ Yes If yes, when and describe:

14. Describe Injury and Tell How It Happened:

15. Have You Seen Any Other Doctor for This Injury? ◯ No ◯ Yes If yes, list name and address:	16. Hospitalized As Inpatient? ◯ No ◯ Yes Name of Hospital:

SECTION 3

17. Your First Treatment Date	18. Describe Complaints:

19. Fully Describe Findings on First Examination (Specify Right or Left):

20. Diagnosis:

21. X-Rays? ◯ No ◯ Yes X-Ray Diagnosis:

22. Is Condition Work Related? ◯ No ◯ Yes Explain:
◯ Undetermined (Explain):

SECTION 4

23. Treatment Date(s) Since Last Report	24. Next Treatment Date	25. Estimate Length of Further Treatment Days Weeks Months

26. Medically Stable? ◯ No ◯ Yes	27. Date of Medical Stability	28. Injury May Permanently Preclude Return to Job at Time of Injury ◯ No ◯ Yes ◯ Undetermined	29. Will Injury Result in Permanent Impairment? ◯ No ◯ Yes ◯ Undetermined

30. Impairment Rating	31. Factors on Which Rating is Based

32. Released for Work ◯ No Estimate Length of Disability ◯ 1-3 Days ◯ 4-7 Days ◯ 8-14 Days ◯ 15-21 Days ◯ 22-28 Days ◯ More ____ Weeks ____ Months
◯ Yes ◯ Regular Work (Date): ◯ Modified Work (Date): Give Limitations:

33. If the number of treatments will exceed Board's frequency standards, state the objectives, modalities, frequency of treatment, and reasons for frequency of treatments. Continue treatment plan on reverse if necessary. GIVE EMPLOYEE AND EMPLOYER/INSURER A COPY OF THIS REPORT.

34. Describe Treatment (and/or Attach Notes)

35. If Case Referred to Another Physician, State Name and Address:				36. IRS I.D. Number
37. Physician's Name and Degree (Print or Type)	38. Physician's Signature			39. Report Date
40. Address	City	State	Zip Code	41. Telephone

SEE INSTRUCTIONS ON BACK

Form 07-6102 (Rev 01/2013)

FINANCIAL AGREEMENT

INSURANCE

As a courtesy to our patients, Northern Chiropractic will bill your health insurance. Also as a courtesy we will verify benefits with your insurance company; this does not guarantee payment for services and is highly recommended that you double check your own benefits with your insurance company either in your plan booklet, online or by calling your insurance company. To process insurance claims quicker, please call your insurance company to answer any questionnaires. Even though an insurance claim is filed, the patient will receive a statement each month indicating the amount owed. This office cannot accept responsibility for collecting your insurance claim, claims denied for medical necessity or for negotiating a settlement on a disputed claim. We expect payment of the portion not covered by your insurance company. All co-pays and fees are due at the time of service. For your convenience, Northern Chiropractic accepts CASH, CHECK, VISA, MASTERCARD and DISCOVER. If needed, financial arrangements are available. Financial arrangements must be discussed and approved.

VA

Northern Chiropractic accepts VA authorizations/referrals. It is the job of the patient to initiate the referral from the VA. As a provider we can request date extensions on already established authorizations, but we cannot request additional visits beyond 26 visits; additional visits must be requested by the veteran. We are unable to schedule additional visits within our office until the additional visits are approved. If you choose to schedule additional visits with the chiropractor or massage therapists you are financially responsible for those visits if they go unpaid by the VA.

NON-INSURED/CASH

All fees are due at the time of service. For your convenience, Northern Chiropractic accepts CASH, CHECK, VISA and MASTERCARD. If needed financial arrangements are available. Financial arrangements must be discussed and approved.

WORKERS'COMPENSATION

Chiropractic services are covered by Workers' Compensation law, and you should be covered 100%, as long as your employer is aware you were injured on the job and you have completed the necessary required paperwork. We will bill your Workers' Compensation Carrier. However, should a controversion arise, please be advised you are responsible for any outstanding amounts. If needed, Northern Chiropractic will assist you with any claims filed as much as possible.

MEDICARE

It is Federal Law that we charge for all services provided. Medicare does not pay for X-rays, examinations, physical therapy, maintenance care, supplements or supplies when ordered and delivered by a chiropractic physician. There may be other non-covered services you will be responsible for. If you have a supplemental insurance policy that covers chiropractic we will bill them for you if Medicare does not. All co-pays and fees are due at the time of service. For your convenience, Northern Chiropractic accepts CASH, CHECK, VISA and MASTERCARD. If needed financial arrangements are available. Financial arrangements must be discussed and approved.

MEDICAID

Dr. Culbert is a participating Medicaid provider and will bill covered services as a courtesy as long as we have your current information on file, and you provide us with a copy of your monthly eligibility coupon or Denali Kid Care card. All co-pays and fees are due at the time of service. Examinations, any x-rays and adjustments NOT related to the spine and any physical therapy modalities are NOT covered by Medicaid and are the patient/guardian's financial responsibility. For your convenience, Northern Chiropractic accepts CASH, CHECK, VISA, MASTERCARD and DISCOVER. If needed financial arrangements are available. Financial arrangements must be discussed and approved.

IT MUST BE UNDERSTOOD

1. Northern Chiropractic **DOES NOT** guarantee that an insurance company will pay. Nor does the clinic promise that an insurance company should pay the fees as charged.
2. Northern Chiropractic will not enter into a dispute with an insurance company for a reimbursement or the amount of reimbursement. The contract is between the patient and the insurance company, therefore, it is the patient's responsibility to see to it the insurance company pays its portion.

Patient/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

Northern Chiropractic, PC
11723 Old Glenn Hwy., Ste 101
Eagle River, AK 99577

Electronic Health Records Intake Form

In compliance with Medicare requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

Informed Consent Document

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment that I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination and treatment, you are consenting to some or all of the following procedures:

__ Spinal manipulative therapy	__ Palpation	__ Vital Signs	__ Range of motion testing
__ Orthopedic testing	__ Postural analysis	__ Ultrasound	__ Basic neurological tests
__ Muscle strength testing	__ Radiographic studies	__ EMS	__ Hot/cold therapy
__ Deep tissue massage	__ Manual therapy		

The material risks inherent in chiropractic adjustment.

As with any other healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would not otherwise come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature or other treatment options.

Other treatment options for your condition may include:

- Self-administered, over the counter analgesics and rest.
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers.
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Gregory Culbert and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ **Dated:** _____

Patient's Name: _____ **Doctor's Name:** _____

Signature: _____ **Signature:** _____

Signature of Parent or Guardian (if a minor): _____

NORTHERN CHIROPRACTIC, PC

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Patient ID #: _____

I hereby acknowledge that I have received a copy of NORTHERN CHIROPRACTIC, PC's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

_____

_____

_____

_____

_____

- ☐ Other (Specify)

_____

_____

_____

_____

_____

NORTHERN CHIROPRACTIC, PC

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize_____ to use and/or disclose my protected health information as described below to:

(name and address of recipient) Northern Chiropractic, PC

11723 Old Glenn Highway, Suite 101, Eagle River, AK 99577

for the following purposes: **(describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)**

_____

_____

I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying NORTHERN CHIROPRACTIC, PC in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) NORTHERN CHIROPRACTIC, PC agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Marketing:

☐ If this box has been checked by the practice, I understand that the practice will receive compensation for using or disclosing my information for marketing purposes.

Type of Information to Be Disclosed

☐ Entire Medical Record	☐ Most Recent 5 Year History	☐ Radiology Reports
☐ Office Chart Notes	☐ All Hospital Records	☐ Operative Reports
☐ Billing Statements	☐ Transcribed Hospital Reports	
☐ Dental Records	☐ History and Physical Exam	☐ Other _____
☐ Laboratory Reports	☐ Emergency and Urgent Care Records	
☐ Pathology Reports	☐ Medical Records for Continuity of Care	_____
☐ Consultation	☐ Diagnostic Imaging Reports	
☐ Discharge Summary	☐ Emergency Room Reports	_____

In addition, I authorize that this will include health information relating to (check if applicable):

☐ HIV/AIDS infection ☐ Drug/Alcohol abuse ☐ Genetic Testing

Expiration:

This authorization will expire 180 days from the date of signing or **(insert date)** _____.

Patient Name: _____ **Patient ID #:** _____

_____ _____

Signature of Patient or Legal Representative **Date**

Relationship to Patient (*if applicable*)

☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

_____

Printed Name of Patient's Representative (*if applicable*)

_____ _____

Signature of Witness **Date**