Richard A. Watson, D.C.

9570 Nesbit Ferry Road ♦ Suite 101 ♦Alpharetta, Georgia 30022
(770) 641-0029 Office ♦ (770) 643-7845 FAX
www.drrickwatson.com

Welcome! We'd like to get to know you!

DATE: _____

About You...

Patient Name: _____
Last *First* *Middle Initial*
Name Preference: _____ □ *Male* □ *Female*
DOB: ____/____/____ **Age:** _____ **Social Security #:** _____
Mailing Address: _____ **Apt. #:** _____
City: _____ **State:** _____ **Zip:** _____
Home Phone #: _____ **Mobile Phone #:** _____
Work/Alt. Phone #: _____ Ext: _____
E-Mail Address: _____
Status: □ *Minor* □ *Single* □ *Married* □ *Separated* □ *Divorced* □ *Widowed*
If married, spouse's name: _____
Children: □ Yes □ No *(If "Yes," how many? _____)*

Employer: _____
Employer's Address: _____
City: _____ **State:** _____ **Zip:** _____
Occupation: _____ **How Long?** _____
Referred by: _____

In the Event of an Emergency,...

Whom should we contact? _____ **Contact's Phone #:** _____
Relationship: □ *Spouse* □ *Parent* □ *Sibling* □ *Son* □ *Daughter* □ *Friend*
Who is your Medical Doctor/PCP? _____ **Phone #:** _____

Account Information...

Person ultimately responsible for account (*Full Name, please.*): _____
Relationship: □ *Self* □ *Spouse* □ *Parent* □ *Sibling* □ *Son* □ *Daughter* □ *Friend*
Billing Address: _____
City: _____ **State:** _____ **Zip:** _____ **Home Phone #:** _____
Work/Alt. Phone #: _____ **S.S. #:** _____

_____ ***"I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company (if offered at this office)."***

PLEASE CONTINUE ON BACK ----------→

Patient Name (continued): _____

REASON FOR VISIT

Please explain the reason for this visit: _____

_____

Please describe the pain and its location: _____

_____

When did current condition begin? _____/_____/_____ **Is this condition getting worse?** □ Yes □ No
Duration: □ Constant □ Comes & Goes
Is this condition interfering with (*Please check all that apply.*): □ Work? □ Sleep? □ Daily Routine?
If so, please explain: _____

_____

HEALTH HISTORY

Are you taking any of the following medications? □ Nerve Pills □ Pain Killers □ Muscle Relaxants
□ Stimulants □ Blood Thinners □ Tranquilizers □ Insulin □ Other(s): _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack/Stroke	Y N Heart Murmur	Y N Anemia
Y N Heart Surg./Pacemaker	Y N Artificial Valves	Y N Rheumatic Fever
Y N Congenital Heart Defect	Y N Hepatitis	Y N Ulcers/Colitis
Y N Mitral Valve Prolapse	Y N Cancer	Y N Asthma
Y N Alcohol/Drug Abuse	Y N Venereal Disease	Y N Chemotherapy
Y N HIV+/Aids	Y N Shingles	Y N Arthritis
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Diabetes/Tuberculosis
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Lower Back Problems
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Difficulty Breathing
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Artificial Bones/Joints

Please list any other serious medical condition(s) you have or ever had: _____

_____

Please list anything that you may be allergic to: _____

_____

List previous surgeries/treatments with dates: _____

_____

List any past serious accidents with dates: _____
Family Health History: _____

_____

DO YOU: □ Take Vitamins/Supplements? □ Exercise? / How often? _____ □ Smoke? / How much? _____
Are you on a special diet? □ Yes □ No (Since _____/_____/_____) **Age of your mattress?** _____
Is it comfortable? □ Yes □ No **Are you wearing:** □ Heel Lifts? □ Sole Lifts? □ Inner Soles? □ Arch Supports?
FOR WOMEN, are you: □ Taking birth-control pills? □ Pregnant? / How far along? _____ □ Nursing?

***We invite you to discuss with us any questions regarding our services.** The best health services are based on a friendly, mutual understanding between provider and patient. **Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager.** If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees and any other expenses incurred in collecting your account.

*** "I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed-care organization, to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge, and I understand it is my responsibility to inform this office of any changes to the information I have provided."**

Signature _____ **Date** _____/_____/_____
Adult Patient _____ **Parent or Guardian** _____ **Spouse** _____

CONDITION CHART

Name: _____

Current weight: _____ Height: _____ Feet, _____ Inches

Please describe your condition: _____

_____

_____

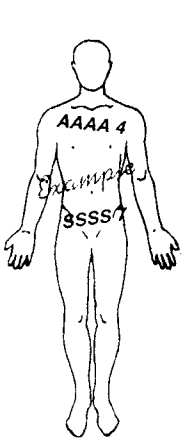
_____

On the diagram below, please...

1) Mark the area(s) at which your symptoms are located, using the following description(s):

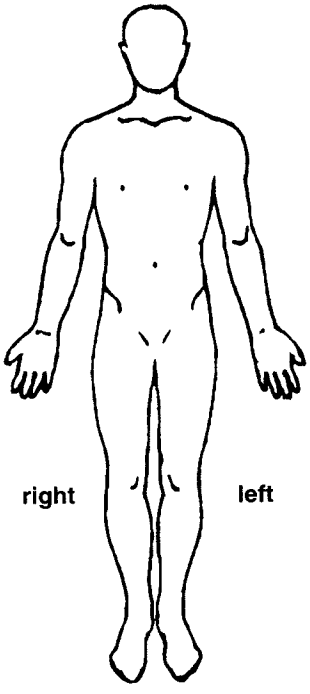
Aching =	AAAA
Burning =	BBBB
Stabbing =	SSSS
Numbness =	NNNN
Pins & Needles =	PPPP

2) Mark the intensity of the symptoms (scale of 1-10, 10 being extreme).

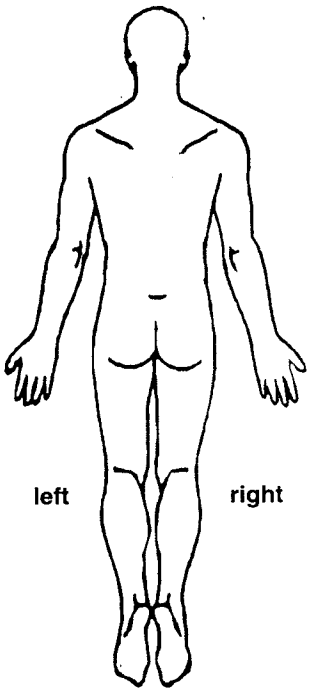


Example

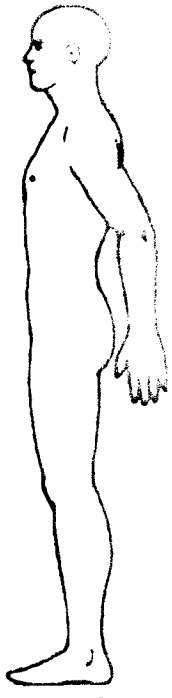

Right



Front



Back


Left

Signature: _____ Date: _____

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FINANCIAL OFFICE POLICY

1. All patients are on a cash basis until their respective insurance coverage and deductibles are verified.

2. If the deductible has not been met, you will be on a cash basis until the deductible has been met.

3. After coverage and deductible are verified, this office may accept assignment on most policies provided the Insured/Patient signs an assignment of benefits and/or lien (authorizing payment to be sent to the doctor).

4. Filing insurance claims and waiting for insurance payment is a **courtesy**.

5. As a patient, it is your responsibility to take care of the co-payment and any non-covered services on a weekly basis. This office may make payment plan arrangements on an individual basis.

6. This office does not warrant or guarantee that your insurance will pay. Nor does this office promise that an insurance company will or should pay the fees charged. **Insurance policies are an arrangement between an insurance carrier and a patient or insured.**

7. We **do not** file secondary or supplemental insurance. We will file with your primary carrier but you will be responsible for filing with the other carrier. The balance on the account after the primary carrier has paid is the patient's responsibility. The only exception is when a Medicare patient has an automatic rollover from Medicare to the secondary or supplemental carrier and they pay us directly. The arrangement for the automatic rollover is the patient's responsibility.

8. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.

9. This office will resubmit a claim **twice**. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

10. All insurance payments are applied to your account as long as any balance is due. This means refunds are made only **after your balance is completely cleared with this office.**

11. If you receive any correspondence or checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken or if the check is on assignment to this office.

12. If there is a change of insurance company, employers, or insurance coverage, it is your responsibility to provide this office with the current information immediately.

13. If your case is a Personal Injury or Workmen's Compensation claim, regardless of your settlement from the insurance company, you are responsible for the account balance.

14. This office accepts MasterCard, Visa, Discover and personal checks. There will be a service charge of $30.00 for returned checks.

15. If you have questions concerning this or any other matter, please speak with us prior to seeing the Doctor.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient Signature (or Responsible Party) **Date**

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Health Insurance Claim Form-1500

ASSIGNMENT OF BENEFITS
&
RELEASE OF INFORMATION STATEMENTS

BOX 2: Patient's *Printed* Name (Last Name, First Name, Middle Initial):

_____

LAST *FIRST* *M.I.*

BOX 12: PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: "I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party, who accepts assignment."

_____ _____

Patient's/Authorized Person's Signature *Date*

BOX 13: INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: "I authorize payment of medical benefits to the undersigned-physician or -supplier for services described below."

_____

Patient's/Authorized Person's Signature

Richard A. Watson D.C.
NOTICE OF PRIVACY PRACTICES

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

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of 4/14/2003, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.
You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. TREATMENT, PAYMENT, HEALTH CARE OPERATIONS: You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows:

> Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
> Payment: We may use and disclose your health information to obtain payment for services we provide to you.
> Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

B. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

C. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

D. MARKETING: We will not use your health information for marketing communications without your written authorization.

E. USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

G. LAW ENFORCEMENT/NATIONAL SECURITY: Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

H. APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

A. ACCESS TO RECORDS: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies and postage if you want the copies mailed to you. A fee for certifying medical records may also be charged not to exceed $7.50. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

B. ACCOUNTING OF CERTAIN DISCLOSURES. Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

D. AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. ELECTRONIC NOTICES. If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

Contact: Richard A. Watson, D.C.
Telephone: 770-641-0029 Fax: 770-643-7845
E-mail:
Address: 9570 Nesbit Ferry Road, Suite 101
Alpharetta, Georgia 30022

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, [patient's name] acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of Richard A. Watson, D.C., which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.

_____ **Date**

_____ **Signature**

_____ **Print Name**

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____ [patient's name]'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

___ Patient Unavailable

___ Patient Physically Unable

___ Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply) :

___ Personally ___ Mail ___ Phone Follow Up

___ Other: _____

_____ Date

_____ Signature

_____ Print Name of Physician

Richard A. Watson D.C.
Name of Practice