Dr. Ashley C. Owens
www.GetWellQuick.com
info@GetWellQuick.com

CAROLINA® CHIROPRACTIC

9380-101 Falls of Neuse Road
Raleigh, NC 27615
919-870-9500 phone
919-870-9502 fax

PATIENT INFORMATION

TODAY'S DATE: _____

Name: _____ Birth Date: _____ Age: _____ Sex: _____
Last Name First Name MI

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: _____ Email: _____

Spouse or Parent(s) Name: _____

In case of emergency, please notify: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION: PLEASE PROVIDE YOUR INSURANCE CARD AS WELL AS A VALID PHOTO ID

INSURED PARTY NAME

Name: _____ Birth Date: _____ Relation to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____

PATIENT EMPLOYER INFORMATION

Name: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

FINANCIALLY RESPONSIBLE PARTY (if other than insured)

Name: _____ Relationship to Patient: _____

Address (if different from patient's): _____ Home Phone: _____

Employer: _____ Address: _____ Work Phone: _____

ASSIGNMENT AND RELEASE

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. Furthermore, I understand that CAROLINA CHIROPRACITC, DR. ASHLEY C. OWENS, 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 CAROLINA CHIROPRACTIC, DR. ASHLEY C OWENS, P.C. will be credited to my account upon receipt. I also give CAROLINA CHIROPRACTIC, DR. ASHLEY C. OWENS, P.C. power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for medical/professional services rendered to me will be immediately due and payable. This assignment and release shall be irrevocable for the full extent of my treatment by CAROLINA CHIROPRACTIC, DR. ASHLEY C. OWENS, P.C. and until such time that my medical/professional expenses incurred have been paid in full. In the event that my account balance becomes overdue and it is necessary to refer it to a collection agency, I will be responsible for paying all costs of collection including, but not limited to, reasonable attorney fees and maximum interest permitted by law. Interest of 1.5% per month of the unpaid balance will be assessed on all overdue accounts. A copy of this assignment and release shall be considered as effective and valid as the original.

_____ _____ _____
Patient/Responsible Party Signature Relationship Date

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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.**

YOUR RIGHTS

Get an electronic or paper copy of your medical record
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights by contacting Patti Shapiro, in our office. If she is unavailable, you may contact Dr. Ashley C. Owens. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- **Treat you**
  We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
- **Bill for your services**
  We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and, preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective September 23, 2013

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NOTICE TO OUR PATIENTS

As of April 2003, all health care providers are required by the Federal Government to advise you how they use your Protected Health Information. This was updated on September 23, 2013 per government regulations. Please read the abridged notice and sign this consent form, which explains that we have made you aware of this Federal Policy. The entire Notice is available if you choose to read it in its entirety. You may also request a written copy.

Nothing in this notice changes the way we provide care, obtain payment, or run our office.

If you have any questions, please ask.

Thank you

Dr. Ashley C. Owens
And the Staff of Carolina Chiropractic

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I acknowledge that I have been advised of Carolina Chiropractic's "Notice of Privacy Practices". I understand I have a right to review Carolina Chiropractic's "Notice of Privacy Practices" prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Carolina Chiropractic. The Notice of Privacy Practices for Carolina Chiropractic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practice also describes my rights and Carolina Chiropractic's duties with respect to my Protected Health Information. Carolina Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail or by asking for one at the time of my next appointment. I have the right to revoke this consent, in writing, except to the extent that Carolina Chiropractic has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of a copy of Carolina Chiropractic's "Notice of Privacy Practices", my understanding, and my agreement to its terms.

_____ _____

Signature of Patient or Personal Representative Date

_____

Description/Relationship of Personal Representative's Authority

This form will be placed in the patient's chart and maintained for six years.

Listed below are the names and relationships of people to whom I authorize Carolina Chiropractic to release my Protected Health Information.

_____ _____

_____ _____

_____ _____

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INFORMED CONSENT
Evaluation and Treatment

PATIENT NAME: _____

Please read this entire document prior to signing it. It is very important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign. Some insurance companies require a written informed consent, and NC state law requires verbal informed consent be obtained by your physician. As a matter of our goal to help you understand your condition and treatment option risks and benefits, we do both as a matter of recognizing your specific needs are unique. We want you to truly understand.

The nature of the chiropractic adjustment

The primary treatment we use as Doctors of Chiropractic is spinal manipulative therapy. If we determine it is appropriate; we will use that procedure to treat you. The doctor's hands or mechanical instruments may be used in such a way as to move your joints, to improve range of motion, relax tight muscles, and decrease nerve irritation. The adjustment may cause a joint noise, "pop" or "click," just as you may have experienced when you stretch your fingers, and feel your knuckles release the surface tension within the joints. You may feel a sense of movement, and restoring motion is a goal of treatment. A good result with a therapeutic trial helps avoid unnecessary testing and procedures.

Analysis / Examination / Treatment

As a part of the evaluation, and presuming treatment, you are consenting to the following procedures when clinically indicated by the chiropractic physician:

manipulative therapy	vital signs	nerve testing
range of motion testing	orthopedic testing	hot/cold therapy
muscle strength testing	postural analysis	exercise/stretches
palpation	electrical stim	taping and support
if needed, radiographic studies	mechanical traction	

Other- standard procedures (explained as utilized)

The material risks inherent in chiropractic and physiotherapy health care professions.

As with any healthcare procedure, there are certain complications which may arise during manipulation/adjustments and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, myelopathy, rib joint strains, pain or irritation of the condition or tissues being treated, and burns. Some types of manipulation of the neck have perhaps been mis-associated timing-wise, with defects or concurrent anatomical blood flow issues within the arteries in the neck; leading to or contributing to serious complications including stroke, which can cause death. Some patients will feel some stiffness and soreness following the first few days of treatment. We try to minimize this with use of therapies and anti-inflammatory remedies as well as ice. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us. Even if you feel it is not related.

The odds of risks occurring are very low. Your biggest risks come from ignoring health concerns.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during review of your health history, during examination and with digital radiographs when indicated. Stroke has been the subject of tremendous confusion. The incidence of stroke is only weakly associated with cervical adjustments, is exceedingly rare and is estimated to occur between one in one million and one in five million. **Your odds of being struck by lightning are 1 in 10 thousand.** Statistically speaking, treatment is often sought during an unfolding health crisis, and treatment is not the cause of an adverse event. The other complications are also generally described as rare. Adverse drug reactions cause 106,000 deaths per year, so helping you get well without unnecessary drug use is beneficial. Statistically, your biggest risk with chiropractic treatment is driving to the office for treatment.

Top 10 Causes of Death - US

1. Diseases of Heart 28.5%
2. Cancer 22.8%
3. Cerebrovascular Diseases (stroke) 6.7%
4. Chronic Lower Respiratory Diseases 5.1%
5. Accidents 4.4%
    - Motor Vehicle Traffic Accidents (41% of all accidents)
    - Poisoning (16% of all accidents)
    - Fall (15% of all accidents)
6. Diabetes Mellitus 3.0%
7. Influenza and Pneumonia 2.7%
8. Alzheimer's Disease 2.4%
9. Kidney diseases 1.7%
10. Septicemia (blood poisoning) 1.4%

All Others 21.4%

The availability and nature of 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-relievers
- Hospitalization
- Surgery

If you choose 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 medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may cause your condition to get worse, cause nerve damage, allow the formation of adhesions, cause arthritis, degenerative changes and reduce mobility which may set up a pain reaction further reducing mobility, and quality of life. Delaying care may complicate treatment making it more difficult to get the best outcome, and less effective the longer treatment is postponed.

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

I have read or have had read to me the above explanation of the chiropractic evaluation, adjustment, and related treatment. I have the opportunity to discuss my care with my chiropractic physician and the ability to get my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing evaluation and treatment and have decided that it is in my best interest to undergo the treatment. Having been informed of the risks, I hereby give my consent to evaluation and treatment.

_____ _____

Patient's Signature Date

_____

Signature of Parent or Guardian (If patient is a minor)

Name_____ I prefer to be called_____ Birthdate_____ Age_____
Check: Single [ ] Married [ ] (Spouse Name_____) Separated [ ] Divorced [ ] Widowed [ ] In relationship [ ]
Occupation_____ Are you a parent: NO YES, Ages of children_____ Adult caretaker_____
COMPLETE ALL THAT APPLY AND ADD ANY COMMENTS
Main reason for today's visit: _____
Date symptoms began: ____/____/____ Describe how condition started: [ ] Lifting [ ] Trauma [ ] Car Accident [ ] Repetitive _____
Circle Discomfort level: 2 Annoying 4 Moderately uncomfortable 5 Dreadful/severe 8 Very severe 10 Unbearable
Describe: [ ] Dull aches [ ] Tight/stiff [ ] Sharp pain w/ movement [ ] Shooting [ ] Burning [ ] Numbness/tingling
How often is your discomfort?
[ ] Constant (76-100% of the time) [ ] Frequent (51-75% of time) [ ] Occasional (26-51% of time) [ ] Intermittent (0-25% of time)
What makes it worse? [ ] Standing [ ] Sitting [ ] Bending/turning [ ] Movement_____
What makes it better?
[ ] Nothing [ ] Standing [ ] Sitting [ ] Lying down [ ] Rest [ ] Activity [ ] Ice [ ] Heat [ ] Medication _____
Prior treatments (date)? NONE Chiropractic ____/____/____ Medical ____/____/____ Other ____/____/____ _____
Prior tests? [ ] NONE [ ] MRI [ ] CAT scan [ ] x-rays [ ] neck [ ] back [ ]extremity [ ] Other ____/____/____ _____
Primary Care Physician _____**Last Physical Exam** ____/____/____ **Specialist** _____
Prior Surgeries/hospitalizations? Or NONE _____
_____
Major diseases/diagnoses? Or NONE _____

Medications: (Prescription and over the counter)

Pain meds:	Muscle relaxers:	NSAIDS: Tylenol/Aleve/Advil/Aspirin
High blood pressure:	Cholesterol:	Diabetes: insulin/non-insulin
Blood thinners:	Birth control:	Anxiety/antidepressants:
Vitamins:	Supplements:	Herbs/Minerals:

Check symptoms you wish to have evaluated today. Circle L (Left) or R (Right) if applicable.

	Headaches
	Occipital (back of head)
	Frontal (forehead, sinus)
	Neck
	Pain - neck
	Stiff - neck
	Muscle spasms
	Shoulders
	Pain - shoulder joint L R
	Stiff - shoulder joint L R
	Can't raise arm L R
	Grinding/popping sounds

	Mid Back
	Pain - mid back
	Stiff - mid back
	Muscle spasms
	Rib/chest pain
	Arms/Hands
	Pain - upper arm L R
	Pain/stiff - elbow L R
	Pain - forearm L R
	Pain/stiff wrist L R
	Numb/tingling L R
	Weakness L R

	Low Back
	Pain - low back
	Pain - pelvis/groin
	Stiff - low back
	Muscle spasms
	Weakness - low back
	Grinding/popping sounds
	Numb/tingling L R

	Hips/Legs/Feet
	Pain - buttocks L R
	Pain - hip joint L R
	Pain - thigh, above knee L R
	Pain - leg, below knee L R
	Numb/tingling thigh/leg L R
	Pain/stiff - knee L R
	Pain/stiff - ankle L R
	Pain/stiff - foot L R heel/arch
	Prior sprain foot/ankle
	Cramps L R
	Weakness L R

Circle all that apply:

Skin: cysts, bruises, cancer	Hormone/reproductive/urine issues	Head: ear, nose, eyes, dizzy, vertigo, sinus
Breathing difficulties: lung, allergies	Loss of bladder/bowel control	Digestive: appetite, heartburn
Circulation: heart, stroke, fainting	Mood: depression, anxiety, nervousness	constipation/diarrhea
Recent fever, weight loss/gain	Sleep disturbance	

Family Diseases (Parents, Siblings):
[ ] Cancer [ ] Diabetes [ ] Heart disease [ ] Stroke [ ] Arthritis [ ] Osteoporosis [ ] Other _____
How much have your symptoms interfered with your usual daily activities: [ ]none, [ ]little bit, [ ]moderately, [ ]quite a bit, [ ]Extremely
Tobacco-chew/dip/cigars/packs/day ____. **Alcohol** drinks/day ____. **Recreational drugs**/day ____. **Caffeine**/day (coffee/tea/soda) _____
Are you on a restricted diet? No/Yes: [ ]Vegan, [ ] Gluten, [ ] Dairy, [ ] Sugar, {] Other_____
What type of regular exercises/hobbies do you perform? [ ] None, [ ] Light, [ ] Moderate, [ ] Strenuous-describe_____
Would you say your health is: [ ] Excellent, [ ] Very good, [ ] Good, [ ]Fair, [ ] Poor
FEMALES: is there any chance you are pregnant at this time? [ ] No [ ] Yes ---Due date ____/____/____

I certify that the above information is correct to the best of my knowledge. _____ ____/____/____
Patient Signature Date