TO THE
New Patient
OUTLINE OF PROCEDURES FOR CARE

STEP ONE:
All new patients are requested to fill out this personal health history questionnaire.

STEP TWO:
A one-on-one consultation with the doctor will be done to discuss your health problems and to determine what may be the cause.

STEP THREE:
A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

STEP FOUR:
The doctor will advise you if additional laboratory tests or x-rays are needed.

STEP FIVE:
You will be given a Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of our treatment recommendations and what results can be obtained. You will also be advised concerning how our office procedures work.

STEP SIX:
If you are accepted as a patient, care will begin. Additional explanations will be given on the different types of treatments that are available in the office.

STEP SEVEN:
An estimate of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of your problem has been obtained.

STEP EIGHT:
After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.
Confidential Patient Health Record

PERSONAL HISTORY

Name: ____________________________
City: ____________________________
Home Phone: ______________________
Social Security #: __________________
Business Employer: __________________
Business Phone: ____________________
Name of Spouse: ____________________
Spouse's Social Security #: __________
Spouse's Employer: __________________
Spouse's Business Phone: ____________
Type of Work: ______________________
Who Is Responsible For Your Bill, You and: □ Spouse □ Workers' Comp. □ Auto Insurance □ Medicare □ Medicaid
□ Personal Health Insurance (Name) __________ Date of Birth __________

CURRENT HEALTH CONDITION

Unwanted Health Condition: ________________________________
Other Doctors Seen For This Condition: □ Yes □ No __________ Who? __________
Type of Treatment: __________________________ Results: __________
When Did This Condition Begin? __________ Has This Condition Occurred Before? □ Yes □ No
Is Condition: □ Job Related □ Auto Accident □ Home Injury □ Fall □ Other: __________
Date of Accident: __________Time of Accident: __________
Have You Made A Report of Your Accident To Your Employer: □ Yes □ No
Drugs You Now Take: □ Nerve Pills □ Pain Killers/Muscle Relaxers □ Blood Pressure Medicine
□ Insulin □ Other __________
Do You Wear A Shoe Lift? □ Yes □ No
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?

PAST HEALTH HISTORY

Please Check and Describe:
Major Surgery/Operations: □ Appendectomy □ Tonsillectomy □ Gall Bladder □ Hernia □ Back Surgery
□ Broken Bones □ Other __________
Major Accident or Falls: __________
Hospitalization (Other Than Above): __________
Previous Chiropractic Care: □ None □ Doctor's Name & Approximate Date of Last Visit __________
Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

[ ] Pneumonia  [ ] Mumps  [ ] Influenza
[ ] Rheumatic Fever  [ ] Small Pox  [ ] Pleurisy
[ ] Polio  [ ] Chicken Pox  [ ] Arthritis
[ ] Tuberculosis  [ ] Diabetes  [ ] Epilepsy
[ ] Whooping Cough  [ ] Cancer  [ ] Mental Disorders
[ ] Anemia  [ ] Heart Disease  [ ] Lumbago
[ ] Measles  [ ] Thyroid  [ ] Eczema

INTAKE
[ ] Coffee  [ ] Tea  [ ] Alcohol
[ ] Cigarettes  [ ] White Sugar

Have you been tested HIV positive?  [ ] Yes  [ ] No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE
[ ] Low Back Pain  [ ] Gas/Bloating After Meals
[ ] Pain Between Shoulders  [ ] Heartburn
[ ] Neck Pain  [ ] Black/Bloody Stool
[ ] Arm Pain  [ ] Colitis
[ ] Joint Pain/Stiffness  [ ] Convulsions
[ ] Walking Problems  [ ] Cold/Tingling Extremities
[ ] Difficult Chewing/Clicking Jaw  [ ] Stress
[ ] General Stiffness

NERVOUS SYSTEM CODE
[ ] Nervous  [ ] Vision Problems
[ ] Numbness  [ ] Dental Problems
[ ] Paralysis  [ ] Sore Throat
[ ] Dizziness  [ ] Ear Aches
[ ] Forgetfulness  [ ] Hearing Difficulty
[ ] Confusion/Depression  [ ] Stuffed Nose
[ ] Fainting  [ ] C-V-R CODE
[ ] Convulsions  [ ] Chest Pain
[ ] Cold/Tingling Extremities  [ ] Short Breath
[ ] Stress

GENERAL CODE
[ ] Fatigue  [ ] Blood Pressure Problems
[ ] Allergies  [ ] Irregular Heartbeat
[ ] Loss of Sleep  [ ] Heart Problems
[ ] Fever  [ ] Lung Problems/Congestion
[ ] Headaches  [ ] Varicose Veins
[ ] Males/Females CODE
[ ] Menstrual Irregularity  [ ] Ankle Swelling
[ ] Menstrual Cramps  [ ] Other Problems
[ ] Breast Pain/Lumps  [ ] Prostate/Sexual Dysfunction
[ ] Prostate/Urinary Problems

GASTRO-INTESTINAL CODE
[ ] Poor/Excessive Appetite  [ ] Constipation
[ ] Excessive Thirst  [ ] Hemorrhoids
[ ] Frequent Nausea  [ ] Liver Problems
[ ] Vomiting  [ ] Gall Bladder Problems
[ ] Diarrhea  [ ] Weight Trouble
[ ] Constipation  [ ] Abdominal Cramps

MALE/FEMALE CODE
[ ] Menstrual Irregularity  [ ] Menstrual Cramps
[ ] Menstrual Pain/Infection  [ ] Breast Pain/Lumps
[ ] Vaginal Pain/Infection  [ ] Prostate/Sexual Dysfunction
[ ] Other Problems

FEMALES ONLY:
When was your last period?  [ ]
Are you pregnant?  [ ] Yes  [ ] No  [ ] Not Sure

GENITO-URINARY CODE
[ ] Bladder Trouble  [ ] Painful/Excessive Urination
[ ] Painful Urination  [ ] Disclored Urine

EENT CODE
[ ] Vision Problems  [ ] Dental Problems
[ ] Dental Problems  [ ] Sore Throat
[ ] Ear Aches  [ ] Hearing Difficulty
[ ] Hearing Difficulty  [ ] Stuffed Nose

Please outline on the diagram the area of your discomfort

FAMILY HISTORY
The following members have a same or similar problem as I do:
[ ] Mother  [ ] Father  [ ] Brother
[ ] Sister  [ ] Spouse  [ ] Child

ANALYSIS:

DIAGNOSIS:

Patient Accepted:  [ ] Yes  [ ] No  [ ] Referred

Doctor's Signature
Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care
☐ Corrective Care
☐ Check here if you want the Doctor to select the type of care appropriate for your condition

Date
Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!

Relief Care
Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care
Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office 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 the Doctor's Office 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 personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature
Date

Consent to Treat a Minor
Date

Guardian or Spouse's Signature of Authorizing Care
Date

Dr. David Singer

FORM #355
To Recorder Call 1-800-548-3676
NOTICE OF PRIVACY PRACTICES
Sparks Family Chiropractic Inc.

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 AND SIGN.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses And Disclosures Of Protected Health Information Based Upon Your Written Consent
You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine or voice mail. To promote a less stressful, friendly and time efficient environment, most office visits are performed in an open area where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office" or office bulletin board unless you specifically request us not to do so. Your private information will be used when we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency.

We may share your protected health information with third party "business associates" that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object
We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or unable to agree or object to the use or disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.
Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your chiropractic care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your chiropractor or another chiropractor in the practice is required by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization:

- When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

You have the right to inspect and copy your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, health operations or additional uses listed above in paragraph 8. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your chiropractor is not required to agree to a restriction that you request. If your chiropractor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your chiropractor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. The terms of this Notice may change. If the terms change, you may receive a revised Notice by contacting our Privacy Contact.

Privacy Contact:

Office Manager 740-689-1175 Fax 740-689-1178

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Sparks Family Chiropractic Inc., staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledged, and understand the content of the Notice of Privacy Practices.

"You May Refuse To Sign This." THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON APRIL 14, 2003.

Printed Patient Name____________________________________ Date__________________

Signature_____________________________________________

Printed Name of Parent/Guardian___________________________

Signature of Parent/Guardian______________________________
Authorization and Assignment

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

1. If I am being seen as a result of a coupon or promotion for a free or reduced price initial exam (including x-rays, and nerve conduction testing), I understand this is for the initial consult, testing and results only. It does not include any chiropractic treatment. This promotional exam is not to be billed to any insurance company.

2. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claims for reimbursement of charges incurred at Sparks Family Chiropractic Inc.

3. I authorize direct payment to you and any sum I now or hereafter owe you by my insurance company or by my attorney out of the proceeds of any settlement of my case, based in whole or in part upon the charges incurred for your services.

4. I understand that any payment received by me, for services rendered in this office are due immediately upon receipt and will be brought into Sparks Family Chiropractic Inc. office to be applied to my account.

Signature: ____________________________ Date: ____________________________
Terms of Acceptance

When a patient seeks chiropractic and we accept a patient for such care, it is essential for both to be working towards the same objective. OUR ONLY PRACTICE OBJECTIVE is to eliminate or improve vertebral subluxation, a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of nerve impulses, resulting in a lessening of the body's ability to express its maximum health potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our method of vertebral subluxation correction is by specific chiropractic adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation, however, if during the course of a chiropractic spinal examination or care, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease or disorder is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my satisfaction and I accept chiropractic care on this basis. I have read and fully understand the above statements, agree to abide by the office policies and payment arrangements outlined above.

_________________________  ________________________
Patient Signature       Date

_________________________  ________________________
Staff Signature        Date
Electronic Health Records Intake Form

In compliance with 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)

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage and Frequency (i.e. 5mg once a day, etc.)</th>
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<tbody>
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Do you have any medication allergies?

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Reaction</th>
<th>Onset Date</th>
<th>Additional Comments</th>
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☐ 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: ___________________________

Height: ______  Weight: ______  Blood Pressure: ______/______
Sparks Family Chiropractic

Name:__________________________________________

Welcome to our office! We want to find out what YOU want from your care in our office. Your goals will become our goals.

If your problem is something that we can help with, will you accept our recommendation? Yes No

Please list 5 things that you want to accomplish if we can help your case:

1.__________________________________________

2.__________________________________________

3.__________________________________________

4.__________________________________________

5.__________________________________________

Do you have any concerns?__________________________________________

Signature_____________________________ Date__________________________