WITTMAN
FAMILY CHIROPRACTIC & SPORTS THERAPY

PATIENT REGISTRATION FORM

Patient's Full Name: _____ Sex: Male or Female
Last First M.I.

Date of Birth: _____ Marital Status: S M D W

Home Address: _____
Street City State ZIP Code

Home Phone: _____ Work Phone: _____ Cell Phone/Other: _____

Spouse/Parent Name and Address: _____

Emergency Contact: _____ Relationship: _____ Telephone #: _____

Primary Care Physician: _____

ACCIDENT INFORMATION

Is this condition due to an accident? YES NO Date of Injury: _____

Type of Accident AUTO WORK HOME OTHER: _____

To whom have you reported of your accident? AUTO INS EMPLOYER WORKER COMP OTHER

Attorney Name: (if applicable): _____

INSURANCE INFORMATION
(Copy of Insurance Card Required)

INSURED/RESPONSIBLE PARTY: (Complete this section regardless of insurance coverage)
You may write "see above" for information where the patient is the actual insured party.

PRIMARY INSURANCE:

Full Name of Insured: _____ Sex: Male or Female
Last First M.I.

Social Security Number: _____ Date of Birth: _____ Marital Status: S M D W

Relationship to Patient: _____

Home Address: _____
Street City State ZIP Code

Home Phone: _____ Work Phone: _____ Cell Phone/Other: _____

Employer Name & Address: _____

Employer Telephone #: _____ Name of Insurance: _____

Group Number: _____ Policy Number: _____

2072 North CR 700 West
Richland, IN 47634

Rebekah A. Wittman, D.C.

(812)686-4192 Phone
(812)359-3000 Fax

SECONDARY INSURANCE:

Full Name of Insured: _____ Sex: **Male or Female**
Last First M.I.

Social Security Number: _____ Date of Birth: _____ **Marital Status: S M D W**

Relationship to Patient: _____

Home Address: _____
Street City State ZIP Code

Home Phone: _____ Work Phone: _____ Cell Phone/Other: _____

Employer Name & Address: _____

Employer Telephone #: _____ Name of Insurance: _____

Group Number: _____ Policy Number: _____

AUTHORIZATION

1. I authorize examination and treatment by Wittman Family Chiropractic as well as the use of this form/information on any/all of my insurance submissions.
2. If I am utilizing my insurance benefits, I authorize the release of information to any insurance listed above.
3. I authorize direct payment to my service provider from the insurance company.
4. I understand that my insurance is a contract between the insurance company and myself and that I am ultimately responsible for the full amount of my bill for services provided.
5. I hereby permit a copy of this form to be used in place of the original.

PROMISE TO PAY

As a service, Wittman Family Chiropractic will bill your insurance company but can not guarantee such benefits or the amounts covered and are not responsible for the collection of such payments. In some instances, an insurance company or other third party payer may consider certain services as not reasonable and necessary or may determine that services are not the usual and customary rates for the area. The person receiving services of the designated responsible party is responsible for payments regardless of my insurance company's arbitrary determination of usual and customary rates. The person responsible for payment of account is financially responsible for paying funds not paid by insurance companies or third party payers within 30 days of patient billing. Should the responsible party fail to make payment, he (she) shall pay all expenses incurred by Wittman Family Chiropractic necessary to recover fees and other damages, including reasonable attorney fees, court costs, and other costs of collection or litigation, whether or not referred for outside collection.

Patient or Guardian Signature: _____ Date: _____

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Notice of Privacy Practices for Protected Health Information

Uses and Disclosures of Protected Health Information

Wittman Family Chiropractic may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the facility has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

Treatment. WFC will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with the facility with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

Payment. Your protected health information will be used, as needed, to obtain payment for the services that WFC provides. This may include certain communications to your health insurance company to get approval for the procedure that has been scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the procedure. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to pathologists for payment of their services.

Operations. WFC may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of the facility and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities, employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

Other Uses and Disclosures. As part of treatment, payment and health care operations, WFC may also use or disclose your protected health information for the following purposes: to remind you of your appointment date, to inform you of potential treatment alternatives or options, to contact you after your treatment as part of our follow up practices, inform you of health-related benefits or services that may be of interest to you, or to contact you to raise funds for the facility or an institutional foundation related to the facility. If you do not wish to be contacted, please contact our Privacy Officer.

Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow WFC to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

When Legally Required. WFC will disclose your protected health information when we are required to do so by any federal, state or local law.

When There Are Risks to Public Health. WFC may disclose your protected health information for the following public activities and purposes:

- To prevent, control,or report disease, injury, or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations, and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

To Report Suspended Abuse, Neglect, or Domestic Violence. WFC may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. WFC will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

To Conduct Health Oversight Activities. IMA may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits

In Connection With Judicial and Administrative Proceedings. WFC may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

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For Law Enforcement Purposes. WFC may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons, or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness, or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the facility has a suspicion that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

To Coroners, Funeral Directors, and for Organ Donation. WFC may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

For Research Purposes. WFC may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

In the Event of a Serious Threat to Health or Safety. WFC may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, federal regulations authorize the facility to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

For Worker's Compensation. The facility may release your health information to comply with worker's compensation laws or similar programs.

Uses and Disclosures Permitted Without Authorization But With Opportunity to Object

WFC may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your treatment or payment related to your treatment. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

Uses and Disclosures Which You Authorize

Other than as stated above, WFC will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

Your Rights

The right to inspect and copy your protected health information. You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the facility uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your information, IMA may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

Please contact the Privacy Officer if you have questions about access to your medical record.

The right to request a restriction on uses and disclosures of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The facility is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the facility 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. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

The right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

The right to request amendments to your protected health information. 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. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

The right to receive an accounting. You have the right to request an accounting of certain disclosures of your protected health information made by WFC. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

The right to obtain a paper copy of this notice. Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

Our Duties

WFC is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the facility changes its Notice, we will provide a copy of the revised Notice upon request by sending a copy of the revised Notice via regular mail or through in-person contact.

Complaints

You have the right to express complaints to WFC and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to IMA by contacting the Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

WFC's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this facility you may submit a complaint to our Privacy Officer by sending it to:

ATTN: Privacy Officer
Physician Billing Service
P O Box 247
Richland, IN 47634

The Privacy Officer can be contacted by telephone at 877-438-6661.

Effective Date

This Notice is effective April 14, 2003.

NOTICE OF PRIVACY PRACTICES

My signature affirms that I have received a printed copy of the Notice of Privacy Practices.

Patient or Guardian Signature: _____ Date: _____

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WITTMAN

FAMILY CHIROPRACTIC & SPORTS THERAPY

CANCELLATION POLICY

Due to our commitment to provide one on one treatment for optimum **patient care, we reserve the right** to charge a **$25 fee** for any no show appointments or **cancellations without 24 hour notice.**

Patient or Responsible Party Signature

Date

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FAMILY CHIROPRACTIC & SPORTS THERAPY

Patient Name: _____ Date: _____

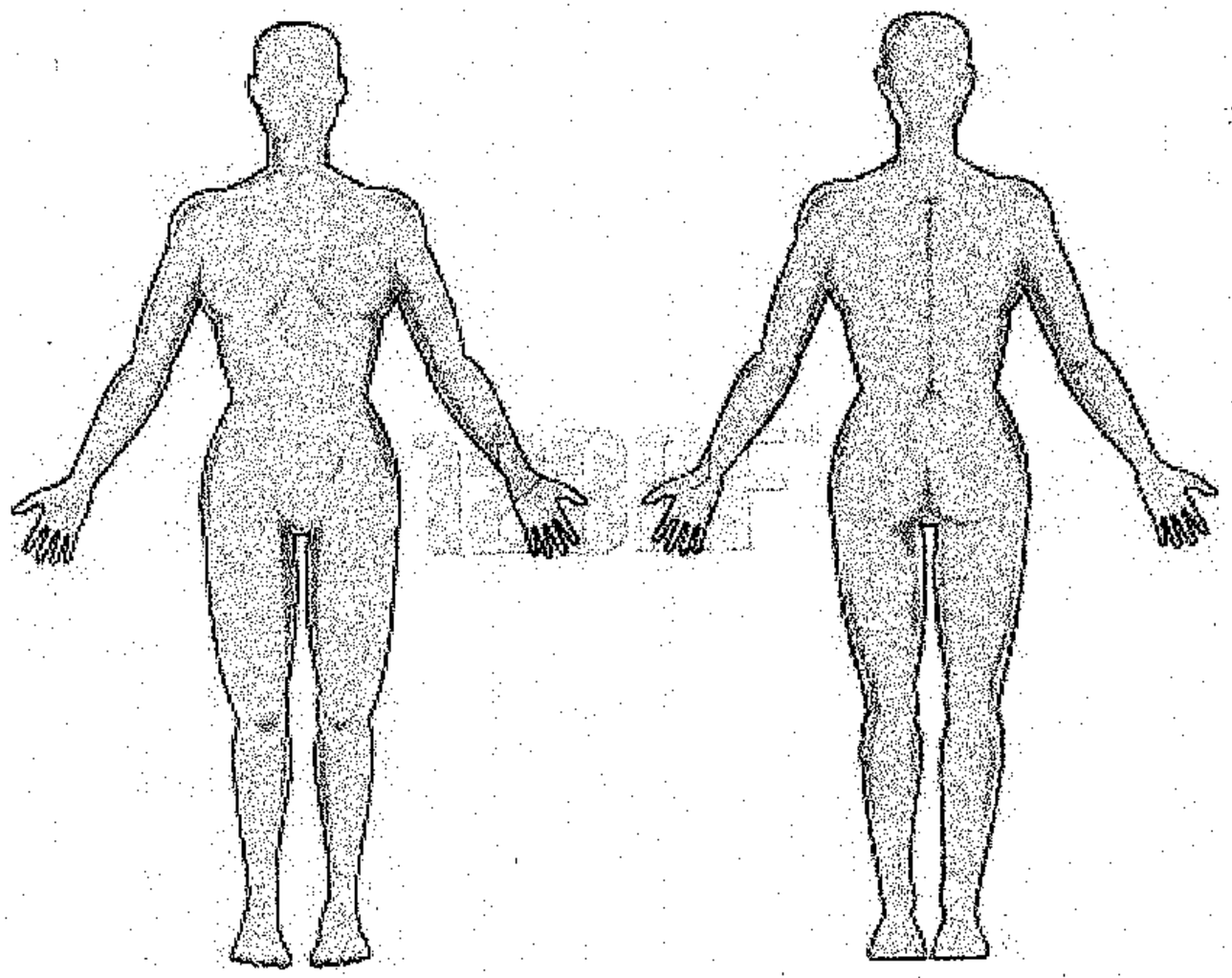
Reason for visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? YES NO **UNKNOWN**

Mark an X on the picture where you continue to have pain, numbness, or tingling.

NOTES:



FRONT BACK

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: SHARP DULL THROBBING NUMBNESS ACHING

SHOOTING BURNING TINGLING CRAMPS STIFFNESS SWELLING OTHER

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: WORK SLEEP DAILY ROUTINE RECREATION

Activities or movements that are painful to perform: SITTING STANDING WALKING BENDING LYING DOWN

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WITTMAN FAMILY CHIROPRACTIC AND SPORT THERAPY
HEALTH HISTORY

Patient Name: _____ Date: _____

What treatment have you already received for your condition? MEDICATIONS SURGERY PHYSICAL THERAPY
CHIROPRACTIC SERVICES NONE OTHER _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ **Blood Test** _____
Spinal Exam _____ Chest X-Ray _____ **Urine Test** _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Circle "Y" for Yes or "N" for No to indicate if you have had any of the following:

AIDS/HIV	Y	N	Emphysema	Y	N	Miscarriage	Y	N	**Suicide Attempt**	**Y**	**N**
Alcoholism	Y	N	Epilepsy	Y	N	Mononucleosis	Y	N	**Thyroid Problems**	**Y**	**N**
Allergy Shots	Y	N	Fractures	Y	N	Multiple Sclerosis	Y	N	**Tonsillitis**	**Y**	**N**
Anemia	Y	N	Glaucoma	Y	N	Mumps	Y	N	**Tuberculosis**	**Y**	**N**
Anorexia	Y	N	Goiter	Y	N	Osteoporosis	Y	N	**Tumors, Growths**	**Y**	**N**
Appendicitis	Y	N	Gonorrhea	Y	N	Pacemaker	Y	N	**Typhoid Fever**	**Y**	**N**
Arthritis	Y	N	Gout	Y	N	Parkinson's Disease	Y	N	**Ulcers**	**Y**	**N**
Asthma	Y	N	Heart Disease	Y	N	Pinched Nerve	Y	N	**Vaginal Infections**	**Y**	**N**
Bleeding Disorder	Y	N	Hepatitis	Y	N	Pneumonia	Y	N	**Venereal Disease**	**Y**	**N**
Breast Lumps	Y	N	Hernia	Y	N	Polio	Y	N	**Whooping Cough**	**Y**	**N**
Bronchitis	Y	N	Herniated Disk	Y	N	Prostate Problem	Y	N	**Other:**		
Bulimia	Y	N	Herpes	Y	N	Prosthesis	Y	N			
Cancer	Y	N	High Cholesterol	Y	N	Psychiatric Care	Y	N			
Cataracts	Y	N	Kidney Disease	Y	N	Rheumatoid Arthritis	Y	N			
Chemical Dependency	Y	N	Liver Disease	Y	N	Rheumatic Fever	Y	N			
Chicken Pox	Y	N	Measles	Y	N	Scarlet Fever	Y	N			
Diabetes	Y	N	Migraine Headaches	Y	N	Stroke	Y	N			

EXERCISE
_____None
_____Moderate
_____Daily
_____Heavy

Are you pregnant? **YES** **NO**

WORK ACTIVITY
_____Sitting
_____Standing
_____Light Labor
_____Heavy Labor

HABITS
_____Smoking Packs/Day _____
_____Alcohol **Drinks/Week** _____
_____Coffee/Caffeine Drinks **Cups/Daily** _____
_____High Stress Level **Reason** _____

DUE DATE: _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Motor Vehicle Accidents		

Medications	Allergies	Vitamins/Herbs/Minerals

Pharmacy Name: _____ Pharmacy Phone **Number:** _____

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