CHIROPRACTIC REGISTRATION INFORMATION

1. PATIENT INFORMATION

Date_____

Name_____

Addrress_____

_____
City State Zip

Home Phone _____ Work_____

Sex ◻ M ◻ F Age_____ Birthdate_____

◻ Single ◻ Married ◻ Widowed
◻ Separated ◻ Divorced

In case of emergency, contact:_____
Name

_____ _____
Relationship Phone

_____
Address City State

Social Security #: _____-_____-_____

Driver's License #:_____

Occupation:_____

Employer:_____

Employer's Address:_____

Spouse's Name:_____

Spouse's Occupation:_____

Spouse's Employer:_____

Whom may we thank for referring you?_____

2. INSURANCE

Person responsible for payment:_____

Relationship to patient:_____

Are you insured? ◻ Yes ◻ No

Health Insurance name:_____

Policy holder's name:_____

Birthdate:_____ SS #:_____

Policy #:_____

Group #:_____

Is the patient covered by additional insurance ? ◻ Yes ◻ No

Company name:_____

Policy Holder:_____

SS#:_____-_____-_____

ID / Group #:_____

3. ACCIDENT INFORMATION

Is your condition due to an accident? ◻ Y ◻ N

Type of accident: ◻ Auto ◻ Work ◻ Other

To whom have reported it to?

◻ Auto ins. ◻ Employer ◻ Other_____

Attorney (if applicable)_____

4. PAYMENT IS EXPECTED AT THE TIME OF VISIT

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that the office of Dr. Bryce C. Hill 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 Dr. Bryce C. Hill will be credited upon receipt, however, I clearly understand and agree that any services rendered me are charged directly to me and that I am personally responsible for payment of my account in full. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered me will be immediately due and payable.

Patient's signature_____ Date_____

Guardian's signature_____ Date_____

5. PATIENT CONDITION

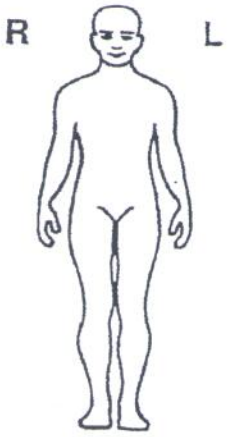
Reason for visit_____

When did your symptoms first appear?_____

Is your condition getting: □ Worse □ Better □ Staying the Same

Mark an "X" on the picture where you have pain, numbness, or other symptoms.

Rate the severity of your symptoms from 1 (least) to 10 (severe)



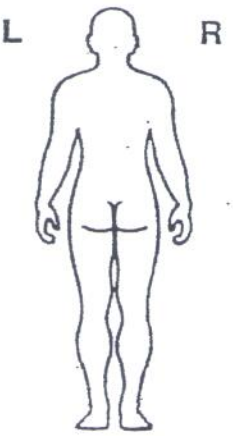
Type of pain: □ sharp □ dull □ achy
□ throbbing □ shooting □ burning
□ numbess □ tingling □ stiffness
□ soreness □ other_____

How often do you have this pain?_____

_____

Other symptoms:

□ headache	□ head seems heavy	□ arm/hand numbness
□ neck pain	□ tension/stress	□ leg/foot numbness
□ neck stiff	□ irritability	□ chest pain
□ loss of balance	□ cold hands/feet	□ depression
□ upper back pain	□ upset stomach	□ light sensitivity
□ mid back pain	□ fatigue	□ memory difficulty
□ lower back pain	□ nervousness	□ difficulty sleeping
□ diarrhea	□ constipation	□ pins/needles
□ ears ringing	□ fainting	□_____



Does it interfere with your: □ work □ sleep □ daily routine □ recreation

□ other _____

What makes it better?_____

What makes it worse?_____

What are your favorite activities?_____

6. HEALTH HISTORY

What treatment(s) have you already tried for your condition? □ medication □ surgery □ chiropractic

□ physical therapy □ none □ other_____

Describe treatment and results_____

Names of other doctors who have treated your condition_____

Have you previously seen a chiropractor? □ Yes □ No

If so, when and for what condition?

Date and results of your last physical exam:_____

Present medication (include non-prescription)_____

_____

Are you pregnant? □ Yes □ No

6. HEALTH HISTORY CONTINUED

Injuries/surgeries you have had : Description Date

Auto Accidents_____

Workers Compensation_____

Falls_____

Other_____

Surgeries_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Allergy Shots	□ Yes □ No	Fractures	□ Yes □ No	Polio	□ Yes □ No
Anemia	□ Yes □ No	Gout	□ Yes □ No	Rheumatoid Arthritis	□ Yes □ No
Appendicitis	□ Yes □ No	Heart Disease	□ Yes □ No	Scoliosis	□ Yes □ No
Arthritis	□ Yes □ No	Hepatitis	□ Yes □ No	Stroke	□ Yes □ No
Asthma	□ Yes □ No	Hernia	□ Yes □ No	Thyroid Problems	□ Yes □ No
Cancer	□ Yes □ No	Herniated Disk	□ Yes □ No	Tuberculosis	□ Yes □ No
Diabetes	□ Yes □ No	High Cholesterol	□ Yes □ No	Tumors/Growths	□ Yes □ No
Depression	□ Yes □ No	Migraines	□ Yes □ No	Ulcers	□ Yes □ No
Emphysema	□ Yes □ No	Osteoporosis	□ Yes □ No	□ Others_____	
Epilepsy	□ Yes □ No	Pacemaker	□ Yes □ No	_____	

STRESSORS

□ Chemical_____

□ Emotional_____

□ Physical_____

EXERCISE

_____

□ None □ Minimal (1-2x/wk) □ Moderate (3-4x/wk) □ Heavy (5-7x/wk)

What Kind?_____

_____

ASSIGMENT OF PROCEEDS, CONTRACTUAL LIEN AND AUTHORIZATION

("Agreement")

I hereby direct any and all insurance carriers, agencies, attorneys, governmental departments, companies, individuals and/or other legal entities ("payers"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("condition"), to pay directly to and exclusively in the name of Dr. Bryce C. Hill, such sums as may be owing to Dr. Bryce C Hill for charges incurred by me, including, but not limited to, charges for treatment, narrative reports, depositions, testimony and any other charges incurred by me at the Office of Dr. Bryce C. Hill. I further grant contractual lien to Dr. Bryce C. Hill with respect to my charges, applicable to all payers, however, I understand that nothing in the Agreement shall be construed as an election by Dr. Bryce C. Hill to claim protection under any statutory lien law. For the purposes of this Agreement, "benefits" shall include, but shall not be limited to, proceeds from any settlement, judgement, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay Dr. Bryce C. Hill, I herby assign, insofar as permitted by law, all of my rights, remedies and benefits to Dr. Bryce C. Hill to the extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name or in the Office's name and settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this Office. I further direct each attorney to provide immediate notice to the Office regarding any funds received by the attorney relating to my accident, to promptly pay such Office and to provide a full accounting of such funds to the Office upon its request.

I hereby direct all payers to release to Dr. Bryce C. Hill any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far and the amount of any outstanding claims.

I authorized this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with the said payers. I hereby authorize Dr. Bryce C. Hill to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorized Dr. Bryce C. Hill to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due to Dr. Bryce C. Hill for his services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its office. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Dr. Bryce C. Hill for all costs of such collection efforts, including, but not limited to, all court cost and all attorney fees up to 50%.

This agreement shall not be modified or revoked without the mutual consent of Dr. Bryce C. Hill and myself. I hereby revoke any previously signed authorizations, whether executed at this Office or any other office to the extent that the terms of those authorizations conflict with the terms of this agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Dr. Bryce C. Hill and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reasons cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient's Name (please print): _____

Patients Signature: _____ Date: _____/_____/_____

Name of Custodial Parent or Legal Guardian (please print): _____

Parent/Guardian's Signature: _____ Date: _____/_____/_____

Hill Chiropractic LLC

1035 W Bellwood Ln, Ste. 175
Murray, UT 84123 (801)967-6000

OFFICE POLICIIES & PROCEDURES AGREEMENT

FINANCIAL ARRANGEMENTS AND POLICIES

I understand and agree that health and accident insurance policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this office with 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 this office will be credited to my account upon receipt. 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 professional services rendered to me will be immediately due and payable.

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for products purchased and services provided by our office. Our office is a participating provider with a number of insurance companies. For your convenience, our office will make an effort to verify your insurance benefits. However, ultimately, it's the patient's responsibility to determine benefits and authorization information before services are rendered. Please note that verification of benefits is not a guarantee of benefits. Your insurance company makes the final determination of insurance benefits when they consider the claim. It is understood that despite our best efforts to provide you with a financial estimate of the cost of care, times arise when insurance companies do no reimburse what was originally quoted. Patients are fully responsible for payment of products and services not authorized or covered by their insurance company. If a referral is required but not provided at the time of your visit, full payment is expected at the time of service. Your signature below will give power of attorney to endorse checks made to **Dr. Bryce C. Hill, DC.**, to be credited to your account.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatment. Payment is due within 30 days of the service rendered. Bills that are delinquent more than sixty (60) days will be transferred to an outside collection agency unless prior arrangements have been made. Patients will be responsible for collection and/or attorney's fees for all such disputes which can be up to 50% of your balance. For any unpaid balances, that are 60 days past due, a monthly fee of 1.5% will be added to your balance. If there are legitimate problems, please discuss them prior to the sixty days so we may find a workable solution.

INFORMED CONSENT TO CHIROPRACTIC CARE

I request and consent to the performance of Chiropractic examination, adjustment/manipulation and any and all other chiropractic procedures permitted by our State law of Utah, including medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible) by any of the treating doctors of chiropractic on staff and/or any licensed chiropractor deemed appropriate by our office. I understand that results of the treatment are not guaranteed. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are associated risks with treatment, although rare, including, but not limited to, fracture, disc injuries, strokes, dislocations, strains and worsening symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known and is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

RECORDS RELEASE AUTHORIZATION & PERMISSION FOR CLINCIAL RESERCH

I hereby grant permission for **Dr. Bryce C. Hill, DC.**, to release any information pertaining to diagnosis and treatment of myself and care in this and other offices to my primary care physician, or to any other physician or therapist whom I am currently or previously under care with. I further authorize this office to utilize information pertaining to my care for the purpose of clinical research, publication and educational purposes, including the use of treatment records and videotaping of my treatment and management in this and other offices for the exclusive study of other Doctors. I realize the necessity of such purposes and understand that the highest ethical standards will be maintained in maintaining patient confidentiality. In accordance with all stated above, I hereby understand and agree to the above stated office policies.

PRINT Patient's name: _____

SIGNATURE of Patient: _____ **Date:** _____

SIGNATURE of Parent or Guardian: _____ **Date:** _____

Witness: _____

Notice of Patient Privacy Rights

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

The office/Practice is committed to maintaining privacy of your protected health information ("PHI"), which includes information about your health condition and the health care you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI

The Office/Practice may use and/or disclose your PHI for the following purposes:

a. **Health care** - In order to provide you with the health care you require, the Office/Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a chiropractor adjusting you for a subluxation in the cervical spine may need to know the results of your latest chiropractic examination by this office.

b. **Payment** - In order to get paid for services provided to you, the Office/Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice, or you, can be properly reimbursed. The Practice may also need to tell your insurance plan about the care you are going to receive so that it can determine whether or not it will cover the health care expenses.

c. **Health Care Operations** - In order for the Office/Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

The office/Practice may also use and/or disclose your PHI without your specific authorization in the following additional instances:

De-identified Information – Information that does not identify you and even without your name, cannot be used to identify you.

a. **Business Associates** - To a business associate if the Office/Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

b. **Personal Representative** – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

c. **Emergency Situations** – for the purpose of obtaining or rendering emergency treatment to you if the opportunity for you to object cannot be obtained due to your incapacity or emergent treatment circumstances and the treatment is consistent with your prior expressed preferences and is in your best interest or to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent serious harm.

Abuse, Neglect or Domestic Violence - To a government authority in the Office/Practice is required by law to make such a disclosure. If the Practice is authorized by law to make such a disclosure, it will so be if it believes that the disclosure is necessary to prevent serious harm.

Health Oversight Activities – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

Judicial & Administrative Proceeding - For example, the Office/Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

Law Enforcement Purpose - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice believes your death was the result of criminal conduct.

Coroner or Medical Examiner - The Office/Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

Research - If the Office/Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.

Avert a Threat to Health or Safety – The Office /Practice may disclose your Phi if it believes disclosure is necessary to prevent or lesson a serious and imminent threat to the health or safety of a person or the public and disclosure is to an individual who is reasonably able to prevent or lessen the threat.

Specialized Government Function – This refers to disclosures of PHI that related primarily to military and veteran's activity.

Workers Compensation – If you are involved in a Workers' Compensation claim, the Office/Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

National Security and Intelligence Activities – The Office/Practice may disclose your PHI in order to provide authorized governmental officials with necessary intelligence

information for national security activities and purposes authorized by law.

Military and Veterans – If you are a member of the armed forces, the Office/Practice may disclose your PHI as required by the military command authorizes.

Fundraising – In order to conduct or assist business associates and/or other institutionally related foundations raise funds for a charitable purpose, such as local hospital, the American Red Cross or other private or public disaster relief agency, Breast Cancer or AIDS-related research, etc. , this Office/Practice may give out demographic information about you as well as any dates health care was provided to you without your specific authorization. However, if this Office/Practice does engage in any fundraising activity, it must include instructions how you may decline to receive further fundraising communication from the Office/Practice.

APPOINTMENT REMINDER

The Office/Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice: a) a postcard mailed to you at the address provided by you; and b)telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

DIRECTORY/SIGN-IN LOG

The Office/Practice maintains a directory of a sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's located within the Practice's office suite. This information may be seen by and is accessible to, others who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS

The Office/Practice may disclose to your family member, other relative, a close personal friend, or any other reason identified by you, your PHI directly relevant to such person's involvement with you care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or location) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

If you are present at or prior to the use or disclosure of your PHI, the Office/Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

If you are not present, the Office/Practices will in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

You have the right to:

Revoke any Authorization in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Office/Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request **unless** the information is needed in order to provide you with emergency treatment.

Receive confidential communication or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the practice (unless the individual or the entirety that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information you would be permitted to inspect and copy and /or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of the disagreement.

Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six years and must not include dates before April 14, 2003. The request should indicate in what form you want the list (such as paper or electronic copy). The first list you request within a twelve month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

Receive a paper copy of this Privacy Notice from the Office/Practice upon request to the Practice's Privacy Officer.

Complain to the Officer/Practice or to the Secretary of HHs if you believe your privacy rights have been violated. To file a complaint with the Office/Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer, Dr. Bryce C. Hill, DC. At 801-968-5400 or via email at katbhill@aol.com.

PRACTICE'S REQUIREMENTS

The Office/Practice:

- Is required by federal law to maintain the privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- Is required by State Law to maintain a higher level of confidentiality with respect to certain portions of your medical information than is provided for under federal law.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that is maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of _____/_____/_____.