Pt #_____
Date_____

CONFIDENTIAL HEALTH HISTORY

LAST NAME _____ FIRST _____ MIDDLE INITIAL _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE_____

HOME PHONE _____ CELL/PGR _____ E-MAIL_____

EMPLOYER _____ WORK PHONE _____ EXT. _____

OCCUPATION_____ BIRTHDATE_____ SEX _____ AGE _____

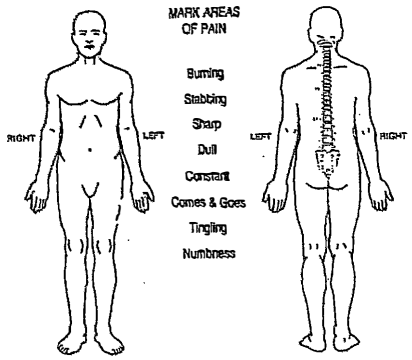
SPOUSE'S NAME _____ EMPLOYER_____

WHO REFERRED YOU TO OUR OFFICE?_____

HAVE YOU OR ANY RELATIVE RECEIVED CHIROPRACTIC TREATMENT PREVIOUSLY? _____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION BY A PHYSICIAN IN THE LAST YEAR? _____

Please mark areas of pain or injury on the illustrations below and give a word description of the symptoms you are experiencing in those areas.



PLEASE MARK YOUR AREAS OF CONCERN:

musculo-skeletal system
- ____ low back
- ____ muscle jerking
- ____ pain btwn shoulders
- ____ neck problems
- ____ arm problems
- ____ leg problems
- ____ painful joints
- ____ sore/weak muscles
- ____ broken bones

genito-urinary system
- ____ bladder trouble
- ____ excessive urination
- ____ painful urination

gastro-intestinal system
- X poor appetite
- ____ excess hunger
- ____ nausea
- ____ vomit (blood)
- ____ excessive thirst
- ____ difficult swallowing
- ____ abdominal pain
- ____ diarrhea/constipation
- ____ black/bloody stools
- ____ liver trouble
- ____ weight loss/gain

nervous system
- ____ numbness
- ____ paralysis
- ____ dizziness
- ____ fainting
- ____ headaches
- ____ convulsions
- ____ forgetfulness
- ____ confusion
- ____ depression

cardio-vascular system
- ____ chest pain
- ____ difficult breathing
- ____ persistent cough
- ____ cough blood
- ____ irregular heartbeat
- ____ high bloodpressure
- ____ lung problems
- ____ varicose veins
- ____ high cholesterol

eye, ear, nose, throat
- ____ blurred vision
- ____ ear aches
- ____ nose bleeding
- ____ dental problems
- ____ sore throat
- ____ difficult speech

female system
- ____ vaginal pain/bleeding
- ____ breast pain/lumps

In case of emergency please notify_____
address_____
phone_____

I UNDERSTAND ALL TREATMENTS, XRAYS AND EXAMINATIONS ARE TO BE PAID FOR AS THEY ARE RECEIVED OR A DEFINITE FINANCIAL ARRANGEMENT MADE IN ADVANCE

_____ _____
SIGNATURE DATE

MICHAEL C. POLSON, D.C.

Polson Family Chiropractic

1750 BROAD PARK CIRCLE SOUTH, STE. 302 1750 MANSFIELD, TX 76063 817.473.1849 E-mail N8INATE@AOL.COM

OFFICE POLICY

(Initial)___ **MISSED** APPOINTMENT POLICY: The fee for "No Show" of a scheduled appointment is $20.00. Please call 2 hours in advanced to reschedule and avoid being charged.

(Initial)____ RETURNED CHECK POLICY: Returned check fee is $20.00.

(Initial)____ MEDICAL RECORDS AND X-RAYS: X-rays performed and medical records generated are property of Polson Family Chiropractic. With your written request a copy will be sent to any doctor's office, fee to copy most recent X-rays $50.00 or $10.00 per film. X-rays will be sent as soon as payment is received. Fee to copy medical records $25.00.

(Initial)____ I ACCEPT FULL RESPONSIBILITY FOR PAYMENT OF ALL FEES ASSOCIATED WITH MY TREATMENT AND ALL COSTS IN COLLECTION OF SAID FEES.

(Initial)____ I UNDERSTAND NO GUARANTEE OR WARRANTY HAS BEEN MADE TO ME THAT RESULTS WILL BE TO MY COMPLETE SATISFACTION.

(Initial)____ UPON MY TERMINATION OF TREATMENT, I WILL PAY ANY REMAINING BALANCE DUE IN FULL IMMEDIATELY.

(Initial)____ I GIVE DR. POLSON LIMITED POWER OF ATTORNEY TO ENDORSE THE PATIENTS NAME UPON PAYMENTS RECEIVED.

I HAVE READ THE ABOVE, UNDERSTAND AND CONSENT TO TREATMENT.

Signature: _____ Date: _____

Witness: _____

MICHAEL C. POLSON, D.C.

Polson Family Chiropractic

1750 Broad Park Circle South, Ste. 302 MANSFIELD, TX 76063 817.473.1849 E-mail N8INATE@AOL.COM

Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Dr. Michael C. Polson, D.C. and/or Polson Family Chiropractic aka (CLINIC) is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from us. The creation of a record detailing the care and services you receive helps this clinic to provide you with quality health care. This Privacy Notice details how your PHI may be used and disclosed to third parties and also details your rights regarding your PHI.

Disclosure for Treatment, Payment, and Operations Purposes

CLINIC may use and/or disclose your PHI for the purposes of:

(a) Treatment – In order to provide you with the health care you require, CLINIC will provide your PHI to those health care professionals, whether on CLINIC's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, another physician treating you for any specific condition may need to know the results of your latest physician examination by this office.

(b) Payment – In order to get paid for services provided to you, CLINIC will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, CLINIC may need to provide your insurance program with information about health care services that you received in this clinic so that we can be properly reimbursed. CLINIC may also need to tell your insurance plan about treatment you will receive so that it can determine whether or not it will cover the treatment expense. (c) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for CLINIC to continue to provide quality and efficient care, it may be necessary for us to compile, use, and/or disclose your PHI. For example, CLINIC may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

NO CONSENT REQUIRED

CLINIC may use and/or disclose your PHI without a written Consent from you in the following instances:

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

(b) Business Associate – To a business associate if CLINIC 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 us 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.

(c) Personal Representative – To a person who, under applicable law, has the authority to represent you, making decisions related to your health care. (d) Emergency Situations –

(i) for the purpose of obtaining or rendering emergency treatment to you provided that we attempt to obtain your Consent as soon as possible; or

(ii) 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.

(e) Communication Barriers – If, due to substantial communication barriers or inability to communicate, we have been unable to obtain your Consent and we determine, in the exercise of our professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.

(g) Abuse, Neglect or Domestic Violence - To a government authority if CLINIC is required by law to make such disclosure. If CLINIC is authorized by law to make such a disclosure, it will do so if we believe that the disclosure is necessary to prevent serious harm.
(h) 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.
(i) Judicial and Administrative Proceeding - For example, CLINIC may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
(j) Law Enforcement Purposes - 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, we may disclose your PHI if we believe that your death was the result of criminal conduct.
(k) Coroner or Medical Examiner - CLINIC may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
(l) Research - If CLINIC 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.
(m) Avert a Threat to Health or Safety - CLINIC may disclose your PHI we believe that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
(n) Specialized Government Functions - This refers to disclosures of PHI that relate primarily to military and veteran activity.
(o) Workers' Compensation - If you are involved in a Workers' Compensation claim, CLINIC may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.
(p) National Security and Intelligence Activities – CLINIC may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.
(q) Military and Veterans – If you are a member of the armed forces, CLINIC may disclose your PHI as required by the military command authorities.

APPOINTMENT REMINDERS
CLINIC may, from time to time, contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. CLINIC may call you by telephone as an appointment reminder, or leave a message on your answering machine or with the individual answering the phone. CLINIC may also send you birthday cards or information pertinent to your condition, new research, or treatment options to the address provided by you for that purpose.

ACTIVE FILES AND RADIOGRAPHS
CLINIC maintains a file of your current radiograph (x-ray's) to be used during regular active care visits. The file is located in a position where individual patients can readily see who is seeking care in the office, as well as the individual's location with CLINIC's suite. This information may be seen by and is accessible to, others who are seeking care or services in CLINIC. The radiographs will be displayed on regular visits in open to provide the highest quality of service at and maintain an efficient visit.

PATIENT DAILY RECORDS ACTIVE FILES (Travel Cards)
CLINIC maintains a file of your current and recent treatment to be used during regular active care visits. The file is located in a position where individual patients can readily see who is seeking care in the office, as well as the individual's location with CLINIC's suite. This information may be seen by and is accessible to, others who are seeking care or services in CLINIC.

DIRECTORY/SIGN-IN LOG
CLINIC maintains a directory of and 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 location within CLINIC's suite. This information may be seen by, and is accessible to, others who are seeking care or services in CLINIC.

WRITTEN TESTIMONALS
CLINIC maintains a file of testimonials/success stories. Due to the amazing results that chiropractic care produces we share your success stories to motivate those who have not yet achieved their desired results. The public display of your testimonial/success story is 100% optional but is requested. The display/file is located in a position where individual patients are *encouraged* to see who is achieving results or seeking care in the office, as well as the individual's location with CLINIC's suite. This information may be seen by and is accessible to, others who are seeking care or services in CLINIC.

FAMILY/FRIENDS
CLINIC may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. We may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) 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:

(a) If you are present at or prior to the use or disclosure of your PHI, we may use or disclose your PHI if you agree, or if we can reasonably infer from the circumstances, based on the exercise of professional judgment, that you do not object to the use or disclosure.
(b) If you are not present, we 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:

(a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to **Dr. Michael C. Polson, D.C.** (Privacy Officer for CLINIC) or to any of CLINIC's staff members, or
(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, CLINIC is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to any CLINIC staff member. In your written request, you must inform CLINIC of what information you want to limit, whether you want to limit CLINIC's use or disclosure, or both, and to whom you want the limits to apply. If CLINIC agrees to your request, we will comply with your request unless the information is needed in order to provide you with emergency treatment.
(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to **Dr. Michael C. Polson, D.C. ,** or any of CLINIC's staff members. CLINIC will accommodate all reasonable requests.
(d) Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to **Dr. Michael C. Polson, D.C. ,** or any of CLINIC's staff members. CLINIC 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, CLINIC 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.
(e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to **Dr. Michael C. Polson, D.C.**. You must provide a reason that supports your request. CLINIC 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 CLINIC (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by CLINIC, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with CLINIC's denial, you will have the right to submit a written statement of disagreement.
(f) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to **Dr. Michael C. Polson, D.C. ,** or any CLINIC staff member. The request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but CLINIC may charge you for the cost of providing additional lists. CLINIC will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.
(g) Receive a paper copy of this Privacy Notice from CLINIC upon request to **Dr. Michael C. Polson, D.C. ,** or any CLINIC staff member.
(h) Complain to **Dr. Michael C. Polson, D.C. ,** or to the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with CLINIC, you must contact **Dr. Michael C. Polson, D.C. .**

All complaints must be in writing.
(i) To obtain more information on, or have your questions about your rights answered; you may contact **Dr. Michael C. Polson, D.C.** at 1811 N. HWY 287 STE. 120 MANSFIELD, TX 76063 817.473.1849, or via email at N8INATE@AOL.COM

CLINIC'S REQUIREMENTS
CLINIC :

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing our legal duties and privacy practices with respect to your PHI.
(b) Is required to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law where state and federal laws conflict, and where state law is more stringent in the area of privacy.
(c) Is required to abide by the terms of this Privacy Notice.
(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
(e) Will distribute any revised Privacy Notice to you prior to implementation.
(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE This Notice is in effect as of 06/24/2005

Dr. Michael C. Polson, D.C.
Privacy Officer for CLINIC-Dr. Michael C. Polson, D.C. and /or
Polson Family Chiropractic

MICHAEL C. POLSON, D.C.

Polson Family Chiropractic

1750 BROAD PARK CIRCLE SOUTH, STE. 302 MANSFIELD, TX 76063 817.473.1849 E-mail N8INATE@AOL.COM

PRIVACY NOTICE

PATIENT **CONSENT FOR USE** AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

With my signature below, I give consent for Dr. Michael C. Polson, D.C. and/or Polson Family Chiropractic to use and/or disclose information about me (or someone else for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations.

I have reviewed and received the Privacy Notice of this Practice prior to signing this consent. The Privacy Notice may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

The Practice may communicate confidential information to me, including any invoices for services, at the following;
Address: _____
Phone numbers: Home_____-_____. Work___-_____Cell_____-_____
Fax ____-_____

e-mail address: _____@_____
The Practice may communicate confidential information about me to the following individual(s):

_____	_____
Name of Individual (Printed)	Signature of individual
_____	_____
Signature of Legal Representative*	Relationship
_____	_____/_____/_____
Witness	**Date**

*Attomey-In-Fact, Guardian, Parent if a minor

MICHAEL C. POLSON, D.C.

Polson Family Chiropractic

1750 BROAD PARK CIRCLE SOUTH, STE. 302 MANSFIELD, TX 76063 817.473.1849 E-mail N8INATE@AOL.COM

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has one primary goal. 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.

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

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

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

Chiropractors, Osteopaths, Medical Doctors using manual manipulation should advise their patients:

1. With neck problems there have been very rare incidents of injury to the vertebral artery during the course of treatment. These have caused stroke or stroke-like occurrences, which are usually of a temporary nature.
2. With back problems there have been rare incidents of rib separation, fracture, disc disease, bruising, swelling or aggravation of symptoms during the course of treatment.

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, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECT WE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the Doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature: _____ Date: _____

Witness: _____

PATIENT'S ACCIDENT REPORT

DATE:_____
NAME OF INJURED PERSON:_____AGE:____SEX:____
ADDRESS:_____
SOCIAL SECURITY NUMBER:_____
NAME AND ADDRESS OF EMPLOYER:_____
_____
PERSON REPORTED INJURY TO:_____

DATE OF INJURY:_____AM PM DATE OF FIRST SYMPTOM:_____
DATE OF FIRST TREATMENT: _____

PATIENT'S ACCOUNT OF HOW INJURY OCCURRED: _____
_____
_____
_____

PAIN LEVEL SELECT THE BEST DESCRIPTION:

BEGINNING	AT PRESENT	
_____	_____	Pain present but forgotten with activity.
_____	_____	Annoying, does not interfere with activity but is not forgotten.
_____	_____	Requires modification of activity but is not disabling.
_____	_____	Unable to perform duties as normal due to pain.
_____	_____	Causes you to cry out in pain, disabling.
_____	_____	Other Describe:_____

AGGRAVATED BY (Makes condition worse):_____
_____

RELIEVED BY:_____
_____

HAVE YOU LOST TIME FROM WORK: Yes No DURATION:_____

HAVE YOU SEEN ANY OTHER PHYSICIANS FOR INJURY: Yes No
List_____.

WERE DRUGS PRESCRIBED BY A PHYSICIAN: Yes No
List_____.

WERE YOU **HOSP**ITALIZED: Yes No WHERE:_____.

OTHER **IMPORTANT** FACTS IN REGARDS TO THE INJURY:_____
_____.

HAVE YOU EVER HAD SAME INJURY BEFORE: Yes No
Describe_____.

HAVE YOU EVER HAD OTHER AUTO OR JOB INJURIES BEFORE: Yes No
Describe_____.

Signature _____.