CONFIDENTIAL HEALTH INFORMATION

Sea Coast Chiropractic and Wellness
Dr. Sean Reese
2210 Wrightsville Avenue Suite 3C
Wilmington, NC 28403
(910) 392-3100

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
○ No ○ Yes When?

Whom may we thank for referring you?

If so, whom?

Gender
○ Male ○ Female

Your Last Name

Your Social Security Number

Your First Name | Your Middle Name (or Initial) | Birth Date (MM/DD/YYYY)

Marital Status
○ Single ○ Married ○ Divorced
○ Widowed ○ Separated

Address

City | State/Province | ZIP/Postal Code | Home Phone | Spouse's Name

Email Address | Cell Phone | Child's Name and Age

Emergency Contact | Phone | Child's Name and Age

Your Occupation | Child's Name and Age

Your Employer

May we contact you at work?
○ Yes ○ No

Preferred method of contact?
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

Address

City | State/Province | ZIP/Postal Code | Work Phone

Insurance Carrier | Policy Number | Primary Care Provider's Name

Insured's Last Name | Birth Date (MM/DD/YYYY)

Who carries this policy?
○ Self ○ Spouse ○ Parent

First Name | Middle Name (or Initial)

Insured's Employer

Address

City | State/Province | ZIP/Postal Code | Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (darken circle): ◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

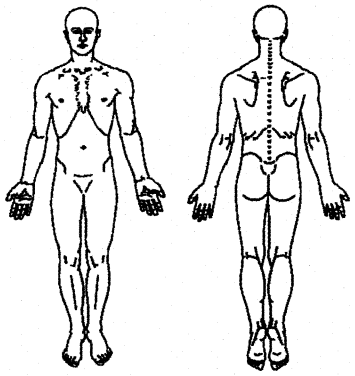
3. Onset (When did you first notice your current symptoms?)
_____

4. Intensity (How extreme are your current symptoms?)
0 ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
◯ Constant ◯ Comes and goes. How Often? _____
_____

6. Quality of symptoms (What does it feel like?)
◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)
_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other _____
◯ Physical therapy ◯ Massage _____

11. What else should Dr. Reese know about your current condition? _____

_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture

NONE ○ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness

NONE ○ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising

NONE ○ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia

NONE ○ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea

NONE ○ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste

NONE ○ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash

NONE ○ Initials ____

Consultation Notes

Patient name _____

Doctor's Initials _____

Sea Coast Chiropractic and Wellness
Dr. Sean Reese

(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	Initials ____

Patient name

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			_____
○	○	Chicken pox			_____
○	○	Diabetes			_____
○	○	Epilepsy			_____
○	○	Glaucoma			_____
○	○	Goiter			_____
○	○	Gout			_____
○	○	Heart disease			_____
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: _____

○ ○ Medications (prescription and over-the-counter):

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

FAMILY

18. Family History

Some health issues are hereditary. Tell Dr. Reese about the health of your immediate family members.

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
_____		○	○			○	○

19. Are there any other hereditary health issues that you know about? _____

_____

SOCIAL

20. Social History

Tell Dr. Reese about your health habits and stress levels.

Alcohol use	○ Daily	○ Weekly	How much? _____	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much? _____	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much? _____	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much? _____	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much? _____	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much? _____	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much? _____			

Hobbies: _____

Consultation Notes

Doctor's Initials

Sea Coast Chiropractic and Wellness
Dr. Sean Reese

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? _____

23. Personal health goals:

- ○ Improve Nutrition/Eating Habits
- ○ Weight Loss/Fat Loss
- ○ Increase Lean Muscle Mass
- ○ Increase Bone Density
- ○ Reduce Stress
- ○ Lower Cholesterol
- ○ Lower Blood Pressure
- ○ Start Exercising
- ○ Look Better
- ○ Feel Better
- ○ Get off Medications
- ○ Improved Sleep
- ○ Improved Energy
- ○ Improved Posture
- ○ Improved Outlook/Happiness

24. On a scale of 1 to 10 with 1=Poor and 10=Excellent, please rate how well you think you are doing in the following categories:

Exercise_____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____ Energy Level_____

25. Do you take: Omega 3 (Fish Oil)? ○ Yes ○ No Vitamin D3? ○ Yes ○ No Probiotics? ○ Yes ○ No

26. Who is your Family Physician or Primary Doctor that monitors you? _____

27. When was the last time you had blood work done? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: _____

_____ Signature

_____ Date (MM/DD/YYYY)

Patient name

Consultation Notes

Doctor's Initials

Sea Coast Chiropractic and Wellness
Dr. Sean Reese

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

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

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **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: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

BACK INDEX

Patient Name _____ **Date** _____

This questionnaire will give your doctor information about how your back condition affects your everyday life. Please answer every section by marking the one statement that *most applies* to you. If two or more statements in one section apply, please mark the one statement that *most closely* describes your current condition.

Pain Intensity

0 - The pain comes and goes and is very mild.

1 – The pain is mild and does not vary much.

2 – The pain comes and goes and is moderate.

3 – The pain is moderate and does not vary much.

4 – The pain comes and goes and is very severe.

5 – The pain is very severe and does not vary much.

Sleeping

0 – I get no pain in bed.

1 – I get pain in bed but it does not prevent me from sleeping well.

2 – Because of pain my normal sleep is reduced by less than 25%.

3 – Because of pain my normal sleep is reduced by less than 50%.

4 – Because of pain my normal sleep is reduced by less than 75%.

5 – Pain prevents me from sleeping at all.

Sitting

0 – I can sit in any chair as long as I like.

1 – I can only sit in my favorite chair as long as I like.

2 – Pain prevents me from sitting more than 1 hour.

3 – Pain prevents me from sitting more than ½ hour.

4 – Pain prevents me from sitting more than 10 minutes.

5 – I avoid sitting because it increases pain immediately.

Standing

0 – I can stand as long as I want without pain.

1 – I have some pain while standing but it does not increase with time.

2 – I cannot stand for longer than 1 hour without increasing pain.

3 – I cannot stand for longer than ½ hour without increasing pain.

4 – I cannot stand for longer than 10 minutes without increasing pain.

5 – I avoid standing because it increases pain immediately.

Walking

0 – I have no pain while walking.

1 – I have some pain while walking but it doesn't increase with distance.

2 – I cannot walk more than 1 mile without increasing pain.

3 – I cannot walk more than ½ mile without increasing pain.

4 – I cannot walk more than ¼ mile without increasing pain.

5 – I cannot walk at all without increasing pain.

Personal Care

0 – I do not have to change my way of washing or dressing in order to avoid pain.

1 – I do not normally change my way of washing or dressing even though it causes some pain.

2 – Washing and dressing increases the pain but I manage not to change my way of doing it.

3 – Washing and dressing increases the pain and I find it necessary to change my way of doing it.

4 – Because of the pain I am unable to do some washing and dressing without help.

5 – Because of the pain I am unable to do any washing and dressing without help.

Lifting

0 – I can lift heavy weights without extra pain.

1 – I can lift heavy weights but it causes extra pain.

2 – Pain prevents me from lifting heavy weights off the floor.

3 – Pain prevents me from lifting heavy weights off the floor but not if positioned on a table.

4 – Pain prevents me from lifting heavy weights off the floor but not medium weight from a table.

5 – I can only lift very light weights.

Traveling

0 – I get no pain while traveling.

1 – I get some pain while traveling but none of my usual forms of travel make it worse.

2 – I get extra pain while traveling but it does not cause me to seek alternate forms of travel.

3 – I get extra pain while traveling which causes me to seek alternate forms of travel.

4 – Pain restricts all forms of travel except that done while lying down.

5 – Pain restricts all forms of travel.

Social Life

0 – My social life is normal and gives me no extra pain.

1 – My social life is normal but increases the degree of pain.

2 – Pain has no significant affect on my social life apart from limiting my more energetic interests.

3 – Pain has restricted my social life and I do not go out very often.

4 – Pain has restricted my social life to my home.

5 – I have hardly any social life because of the pain.

Changing Degree of Pain

0 – My pain is rapidly getting better.

1 – My pain fluctuates but overall is definitely getting better.

2 – My pain seems to be getting better but improvement is slow.

3 – My pain is neither getting better nor worse.

4 – My pain is gradually worsening.

5 – My pain is rapidly worsening.

Index score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100. BACK INDEX SCORE _____

NECK INDEX

Patient Name _____ **Date** _____

This questionnaire will give your doctor information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that *most applies* to you. If two or more statements in one section apply, please mark the one statement that *most closely* describes your current condition.

Pain Intensity

0 – I have no pain at the moment.

1 – The pain is mild and does not vary much.

2 – The pain comes and goes and is moderate.

3 – The pain is fairly severe at the moment.

4 – The pain is very severe at the moment.

5 – The pain is the worst imaginable at the moment.

Personal Care

0 – I can look after myself normally without causing extra pain.

1 – I can look after myself normally but it causes some extra pain.

2 – It is painful to look after myself and I am slow and careful.

3 – I need some help but I manage most of my personal care.

4 – I need help every day in most aspects of self care.

5 – I do not get dressed, wash with difficulty, and stay in bed.

Sleeping

0 – I have no trouble sleeping.

1 – My sleep is slightly disturbed (less than 1 hour sleepless).

2 – My sleep is mildly disturbed (1 – 2 hours sleepless).

3 – My sleep is moderately disturbed (2 – 3 hours sleepless).

4 – My sleep is greatly disturbed (3 – 5 hours sleepless).

5 – My sleep is completely disturbed (5 – 7 hours sleepless).

Lifting

0 – I can lift heavy weights without extra pain.

1 – I can lift heavy weights but it causes extra pain.

2 – Pain prevents me from lifting heavy weights off the floor but not if positioned on a table.

3 – Pain prevents me from lifting heavy weights off the floor but not medium weight from a table.

4 – I can only lift very light weights.

5 – I cannot lift or carry anything at all.

Reading

0 – I can read as much as I want with no neck pain.

1 – I can read as much as I want with slight neck pain.

2 – I can read as much as I want with moderate neck pain.

3 – I cannot read as much as I want because of moderate neck pain.

4 – I can hardly read at all because of severe neck pain.

5 – I cannot read at all because of neck pain.

Driving

0 – I can drive my car without any neck pain.

1 – I can drive my car as long as I want with slight neck pain..

2 – I can drive my car as long as I want with moderate neck pain.

3 – I cannot drive my car as long as I want because of moderate neck pain.

4 – I can hardly drive at all because of severe neck pain.

5 – I cannot drive my car at all because of neck pain.

Concentration

0 – I can concentrate fully when I want with no difficulty.

1 – I can concentrate fully when I want with slight difficulty.

2 – I have a fair degree of difficulty concentrating when I want.

3 – I have a lot of difficulty concentrating when I want.

4 – I have a great deal of difficulty concentrating when I want.

5 – I cannot concentrate at all.

Recreation

0 – I am able to engage in all my recreation activities without neck pain.

1 – I am able to engage in all my usual recreation activities with some neck pain.

2 – I am able to engage in most but not all my usual recreation activities because of neck pain.

3 – I am only able to engage in a few of my usual recreation activities because of neck pain.

4 – I can hardly do any recreation activities because of neck pain.

5 – I cannot do any recreation activities at all.

Work

0 – I can do as much work as I want.

1 – I can only do my usual work but no more.

2 – I can only do most of my usual work but no more.

3 – I cannot do my usual work.

4 – I can hardly do any work at all.

5 – I cannot do any work at all.

Headaches

0 – I have no headaches at all.

1 – I have slight headaches which come infrequently.

2 – I have moderate headaches which come infrequently.

3 – I have moderate headaches which come frequently.

4 – I have severe headaches which come frequently.

5 – I have headaches almost all the time.

Index score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100. BACK INDEX SCORE _____

Authorization and Assignment

Consent for treatment

I the undersigned, a patient in this office, herby authorize Sean Reese, D.C. (and whomever he may designate as his assistant(s)) to administer treatment as is necessary.

I also certify that no guarantees or assurances have been made to me as to the results that may be obtained.

I understand and agree that health or accident insurance policies are an agreement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making any collection from any 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.

This lets the insurance company or attorney pay your bill with any insurance or award proceeds

The undersigned hereby assigns to Sea Coast Chiropractic all rights, title, and interest in and to any compensation or payment in any form that the undersigned received or shall receive as a result of or arising out of the injuries sustained by the patient. The undersigned hereby authorizes and directs any person or corporation having notice of this assignment to pay to Sea Coast Chiropractic directly the amount of the indebtedness owed to Sea Coast Chiropractic in connection with services rendered to the patient.

This says that you are ultimately responsible for your bill.

I understand that I remain personally responsible for the total amounts due on my account(s) with Sea Coast Chiropractic. Signing this form requires that Sea Coast Chiropractic collect payments due at the time services are rendered. If asked, I agree to make payments on my account. I also understand and agree to pay interest on any unpaid balance that is due at the conclusion/termination of the treatment administered at a rate of 1.5% per month (18 percent APR) or as allowed by law, until the balance is paid in full.

This says that we can release information about you/your health to help get the bill paid.

I authorize Sea Coast Chiropractic to release any information, pertinent to my case, to any insurance company, adjuster, and/or Attorney to facilitate collection under this Assignment, Lien, and Authorization.

This lets us sign checks sent to us as a payment on your bill here.

I agree that Sea Coast Chiropractic may endorse, sign my name to any checks sent to the clinic as payment on my account(s).

This alerts you that you will be charged if the account is sent to collection.

If this account is turned over to an attorney or agency for collections, I understand and agree that I will be liable for all expenses incident to the collection of my balance, including attorney fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by me in any way.

Date: _____

Signed: _____ Print: _____

The Office of Sea Coast Chiropractic

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Sea Coast Chiropractic, we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are responsible for the payment of your services).
*Your name, address, phone number, email address and your health care records may be used to contact you regarding appointment reminders, newsletter, and birthday correspondence, to provide information about alternatives to your present care, or for other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.
Under Federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care services to you in an emergency.
* If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
* If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or regarding the status on your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice; we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health records in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rights.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to **Dr. Sean Reese (910) 392-3100.**

If you would like further information about our privacy policies and practices please contact **Dr. Sean Reese (910) 392-3100**.

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open-adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience in our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment, other arrangements will be made for you.

This notice is effective as of _____. This notice, and any alterations or amendments made hereto, will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Signature	Date	Name (Printed Please)

Sean Reese, D.C.
2210 Wrightsville Ave. Suite 3C, Wilmington, NC 28403
Ph 910-392-3100 Fax 910-763-2884
www.seacoastchiropractic.com

Health and Medical Information Release Form

I, _____, give permission to Dr. Sean Reese, his staff, associates, and employees of Sea Coast Chiropractic & Wellness to share private and medical information with my medical doctor, _____, as well as his staff, employees, and associates. Also, my medical doctor, as well as his or her staff, employees, and associates have permission to share personal and medical information with Dr. Sean Reese and his staff.

Signature: _____ Date: _____

Patient Information

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Date of Birth: _____

Medical Doctor Information

Name of Doctor: _____
Address: _____
City, State, Zip: _____
Phone: _____