

PATIENT INFORMATION (PLEASE PRINT)
(Informacion del Paciente)

NAME _____
(NOMBRE) FIRST (APPELLIDO) LAST MIDDLE

HEIGHT _____ **WEIGHT** _____
(Altura) (Peso)

SOCIAL SECURITY NUMBER ____ - ____ - ____ **DATE OF BIRTH** _____ SEX M / F
(NUMERO DE SEGURO SOCIAL) (FECHA DE NACIMIENTO)

ADDRESS _____ **APT. #** _____
(DIRECCION)

CITY _____ **STATE** _____ **ZIP** _____
(CIUDAD) (ESTADO) (CODIGO POSTAL)

HOME PHONE (_____) _____ **CELL PHONE** (_____) _____
(TELEFONO) (TELEFONO CELULAR)

If you would like to receive appointment reminders via text message please provide us with your carrier information: _____

EMAIL ADDRESS _____
(CUENTO DEL CORREO ELECTRONICO)

WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS VIA EMAIL? YES NO

MARITAL STATUS (CIRCLE) SINGLE / MARRIED / DIVORCED / WIDOWED
(SOLTERO(A)) (CASADO(A)) (DIVORCIADO(A)) (VIUDO(A))

EMPLOYMENT (CIRCLE) NONE / FULL-TIME / PART-TIME / STUDENT / RETIRED / DISABLED
(Sin Empleo) (Tiempo Completo) (Tiempo Parte) (Estudiante) (Retirado) (Discapitado)

EMPLOYER _____
(EMPLEO)

OCCUPATION _____
(TRABAJO)

EMPLOYER ADDRESS _____
(DIRECCION DEL EMPLEO)

TELEPHONE _____
(TELEFONO DEL EMPLEO)

SPOUSE / PARENT / EMERGENCY CONTACT INFORMATION
(Esposo/Padre/Contacto en Caso de Emergencia)

(THIS INFORMATION IS **REQUIRED** FOR MINOR PATIENTS OR THOSE WITH GUARDIANS; ALL OTHERS ONLY GIVE AN EMERGENCY CONTACT)

NAME _____
(NOMBRE DEL ESPOSO O PADRE) FIRST LAST (RELACION) RELATIONSHIP

DATE OF BIRTH _____ SEX M / F **PHONE** (_____) _____
(FECHA DE NACIMIENTO) (TELEFONO)

INJURY INFORMATION

DATE OF ACCIDENT/INJURY _____ IS THIS A WORKER'S COMPENSATION CLAIM? YES / NO
(FECHA DEL ACCIDENTE) (SEA UN ACCIDENTE DEL TRABAJO)

Tell us about your injury/complaint (Cuéntanos de tu lesión/queja): _____

HEALTH INSURANCE INFORMATION

(DO NOT COMPLETE IF YOU HAVE YOUR CARD WITH YOU, GIVE THE CARD TO THE RECEPTIONIST)
NO SE COMPLETAN SI TIENES SU TARJETA CON USTED, DARLE LA TARJETA A LA RECEPCIONISTA

INSURANCE COMPANY _____ PHONE NUMBER _____
(ASEGURANZO) (TELEFONO)

ADDRESS _____
(DIRECCION) ADDRESS CITY STATE ZIP

NAME OF INSURED _____ RELATIONSHIP _____
(NOMBRE DE EL ASEGURANZO) (RELACION)

ID # _____ GROUP # _____ EMPLOYER _____
(NUMERO DEL IDENTIFICACION) (NUMERO DEL GRUPO) (EMPLEO)

SOCIAL SECURITY NUMBER _____ - _____ - _____ DATE OF BIRTH _____
(NOMBRE DEL SEGURO SOCIAL) (FECHA DE NACIMIENTO)

HEALTH HISTORY

NAME _____
NOMBRE

DATE _____
FECHA

MEDICATIONS

List all prescription AND/OR over the counter medications you are currently using (*Indique medicamentos de receta del Medico o sin receta que estas usando ahora*):

Place a mark by “yes” or “no” if you have had any of the following: (*Elija todos los que apliquen a usted*)

| CONDITION (Condicion) | YES (Si) | NO (No) | CONDITION (Condicion) | YES (Si) | NO (No) |
|---|----------|---------|--|----------|---------|
| AIDS/HIV <i>SIDA/VIH</i> | | | HEPATITIS <i>HEPATITIS</i> | | |
| ALCOHOLISM <i>ALCOHOLISMO</i> | | | HERNIA <i>HERNIA/QUEBRADURA</i> | | |
| ANEMIA <i>LA ANEMIA</i> | | | HERNIATED DISC <i>HERNIA DE DISCO</i> | | |
| ARTHRITIS <i>ARTRITIS</i> | | | KIDNEY DISEASE <i>ENFERMEDAD RENAL</i> | | |
| ASTHMA <i>ASMA</i> | | | LIVER DISEASE <i>ENFERMEDAD HEPÁTICA</i> | | |
| BLEEDING DISORDER <i>ENFERMEDAD HEMORRAGICA</i> | | | MIGRAINES <i>LAS MIGRAÑAS</i> | | |
| BRONCHITIS <i>BRONQUITIS</i> | | | MONONUCLEOSIS <i>LA MONONUCLEOSIS</i> | | |
| CANCER <i>EL CANCER</i> | | | MULTIPLE SCLEROSIS <i>ESCLEROSIS MÚLTIPLE</i> | | |
| CATARACTS <i>CATARATAS</i> | | | OSTEOPOROSIS <i>OSTEOPOROSIS</i> | | |
| CHEMICAL DEPENDENCY <i>DEPENDENCIA DE DROGAS</i> | | | PARKINSON'S DISEASE <i>LA ENFERMEDAD DE PARKINSON</i> | | |
| DIABETES | | | PINCHED NERVE <i>NERVIO PELLIZCADO</i> | | |
| EMPHYSEMA <i>ENFISEMA</i> | | | PNEUMONIA <i>NEUMONÍA</i> | | |
| EPILEPSY <i>EPILEPSIA</i> | | | PROSTHESIS <i>PRÓTESIS</i> | | |
| FRACTURES <i>FRACTURAS</i> | | | RHEUMATOID ARTHRITIS <i>LA ARTRITIS REUMATOIDE</i> | | |
| GLAUCOMA | | | STROKE <i>DERRAME CERABRAL</i> | | |
| GOUT <i>GOTA</i> | | | THYROID PROBLEMS <i>PROBLEMAS DE LA TIROIDES</i> | | |
| HEART DISEASE <i>ENFERMEDAD CARDIACA</i> | | | TUBERCULOSIS <i>LA TUBERCULOSIS</i> | | |

HEALTH HISTORY – PART 2

1. Have you ever been to a chiropractor? YES / NO
Ha solicitado tratamiento por quiropractico?
2. In the last 24 months (not including this injury) have you been to any of the following?
En los dos años pasados ha solicitado tratamiento con:
- | | | |
|--|----------|------------------|
| a. Medical Doctor (Medico) | YES / NO | LAST VISIT _____ |
| b. Physical Therapist (Terapia Fisica) | YES / NO | LAST VISIT _____ |
| c. Medical Specialist (Especialista) | YES / NO | LAST VISIT _____ |
3. Have you ever had surgery? If yes, please list surgery and year. YES / NO
Indique cirugias; tipo y el año:
- | | |
|---------------|---------------|
| a. Year _____ | Surgery _____ |
| b. Year _____ | Surgery _____ |
| c. Year _____ | Surgery _____ |
4. Have you ever had a broken bone? If yes, please list year and bone. YES / NO
Indique fracturas del hueso y año:
- | | |
|---------------|------------|
| a. Year _____ | Bone _____ |
| b. Year _____ | Bone _____ |
| c. Year _____ | Bone _____ |
5. Have you ever had a work-related injury? If yes, please list year and injury. YES / NO
Ha tenido accidentes del trabajo? Indique tipo y año del herida
- | | |
|---------------|--------------|
| a. Year _____ | Injury _____ |
| b. Year _____ | Injury _____ |
| c. Year _____ | Injury _____ |
6. Do you exercise?
Haces ejercicios? Nunca / A veces / Cada día
NEVER / SOMETIMES / EVERYDAY
7. Describe your activity level while at work.
En su trabajo que haces más? SENTANDO / DE PIE / TRABAJO LIJERO / TRABAJO DURO
SITTING / STANDING / LIGHT LABOR / HEAVY LABOR
8. How many days of work have you missed since this accident / injury? _____
Cuantos días no puede trabajar debido a este accidente?
9. Do you smoke? YES / NO _____ packs/day
Fuma cigarrillos? Cuantos por día?
10. Do you drink alcohol? YES / NO _____ drinks/week
Toma Alcohol? Cuantas bebidas por día?
11. (Women) Are you pregnant? YES / NO _____ due date
(A mujeres) Esta embarazada? Cuantos meses?

DAILY ACTIVITY CHECKLIST

This checklist is designed to help us understand how much discomfort, pain, and/or difficulty you experience while performing your daily activities. Please check (✓) only **ONE** column for each activity that most applies to your level of discomfort.

If you regularly perform an activity that is not listed, please write that activity in the blank boxes at the bottom and indicate your level of discomfort / difficulty. If you have any questions about how to complete this form, the staff will be more than happy to assist you.

Esta lista de verificación es diseñado para ayudar nos comprender cuanto molesta, dolor y/o dificultad experiencias cuando estás haciendo ciertas actividades. Por favor completa la lista de verificación por marcando solamente una columna para cada actividad que mas aplica a tu nivel de molesta, dolor, y/o dificultad para aquella actividad. No marque más que una columna para cualquier actividad. Si una actividad no se aplica porque no hace esa actividad (por ejemplo, si no está empleado, o no tiene niños que cuidar” marca “no aplicable” columna.

| Activity <i>Actividad</i> | Not Applicable <i>No Aplicable</i> | No Discomfort or Difficulty <i>No molesta</i> | Minimal Discomfort or Difficulty <i>Me molesta</i> | Moderate Discomfort or Difficulty <i>Me molesta moderada</i> | Major Discomfort or Difficulty <i>Molesta Mayor</i> | Can't do this because of Discomfort or Difficulty <i>No puedo hacer</i> |
|---|--|---|--|--|---|---|
| Sitting <i>Sentado</i> | | | | | | |
| Standing <i>De pie</i> | | | | | | |
| Bending <i>Agachando</i> | | | | | | |
| Lifting <i>Levantando</i> | | | | | | |
| Walking <i>Caminando</i> | | | | | | |
| Lying Down <i>Acostado</i> | | | | | | |
| Sleeping <i>Dormido</i> | | | | | | |
| Driving <i>Manejando</i> | | | | | | |
| Working <i>Trabajando</i> | | | | | | |
| Housework <i>Limpieza</i> | | | | | | |
| Dressing <i>Vestir se</i> | | | | | | |
| Personal Hygiene <i>Cuidado Personal</i> | | | | | | |
| Caring for Children <i>Cuidado de los niños</i> | | | | | | |
| Using computer <i>Usando Computadora</i> | | | | | | |
| Exercising <i>Ejercicios/Deportes</i> | | | | | | |
| Watching TV <i>Mirando televisor</i> | | | | | | |
| | | | | | | |
| | | | | | | |

Name _____ Date _____ File _____

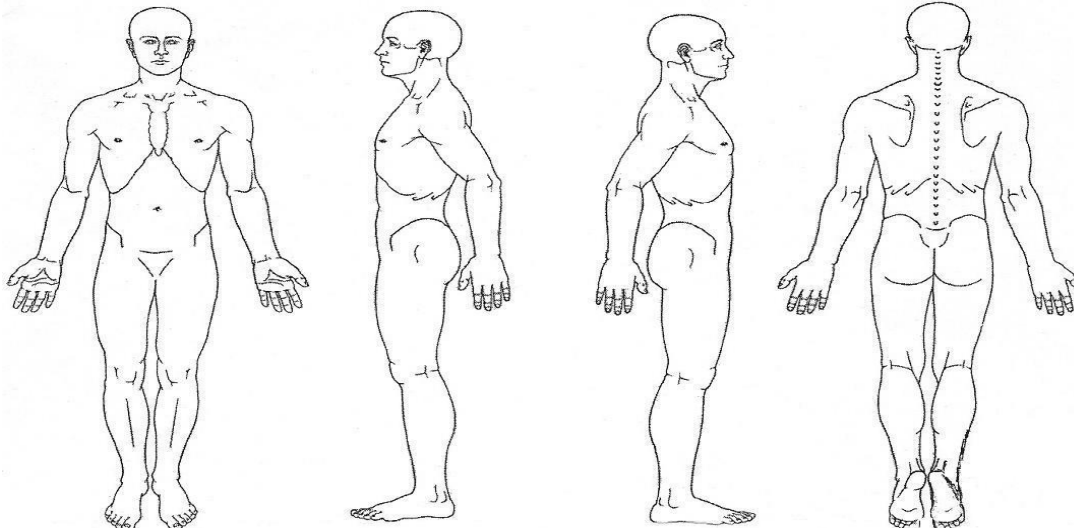
Please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Use appropriate symbols. Mark areas of radiation. Include all affected areas.

DO NOT SIMPLY CIRCLE THE AREA OF INVOLVEMENT PLEASE.

Numbness ---- Pins & Needles oooo Burning xxxx Aching *** Stabbing ////**

Usando los simbolos del abajo; indique las areas en su cuerpo donde se siente las sintomas. Incluye todos los partes que estan afectados.

**Entumido ---- Hormigueo oooo Dolor que quema xxxx
Imple Dolor ***** Punzante ////**



Please place a vertical mark on the line below to indicate the severity of your complaint.

Marque (/) en la linea del nivel de dolor que siente ahorita en la parte mas lastimada entre no dolor y insoportable dolor

| | | |
|--|---------------|---------------------------|
| Headache <i>Dolor de cabeza</i> | No Pain _____ | Worse Pain Experienced |
| Neck Pain <i>Dolor del cuello</i> | No Pain _____ | Worse Pain Experienced |
| Middle Back Pain <i>Dolor de espalda media</i> | No Pain _____ | Worse Pain Experienced |
| Low Back Pain <i>Dolor de espalda baja</i> | No Pain _____ | Worse Pain Experienced |
| Other _____ <i>Otro</i> | No Pain _____ | Worse Pain Experienced |
| Other _____ <i>Otro</i> | No Pain _____ | Worse Pain Experienced |
| Other _____ <i>Otro</i> | No Pain _____ | Worse Pain Experienced |

INFORMED CONSENT

To All of Our Valued Patients:

Every type of healthcare procedure and/or treatment is associated with some degree of risk. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic healthcare before consenting to treatment.

Chiropractic adjustments involve the moving of joints in the body with the use of the doctor's hands, use of a machine, use of a mechanical table, or use of a hand held instrument. Frequently, adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office, we may use trained staff to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, and other treatment modalities. Occasionally when your doctor is unavailable, another chiropractor may treat you. If you do not want to be treated by another chiropractor in this clinic, please inform the staff immediately and that request will be honored.

NATURE AND PURPOSE OF CHIROPRACTIC PROCEDURES

The practice of chiropractic includes many standard examination and testing procedures. These include physical examination, orthopedic and neurological testing, palpation, specialized instrumentation's, laboratory tests, radiology examinations, physical therapy and rehabilitative procedures.

There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. A chiropractic adjustment is the application of a quick precise movement over a very short distance to a specific segmental contact point of a vertebra.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All chiropractic physicians providing care at Back 2 Health LLC are licensed by the Georgia Board of Chiropractic Examiners in accordance with state laws.

POSSIBLE RISKS ASSOCIATED WITH CHIROPRACTIC PROCEDURES

Not only should you understand the benefits of chiropractic care in restoring and maintaining good health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. All health care procedures, including those used in varying degrees, have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include:

- Stroke
- Vertebral disc herniation
- Soft tissue injury
- Rib fractures
- Physical therapy burns
- Soreness

I hereby give consent to Back 2 Health LLC and its employees and/or contract personnel to render treatment to myself and/or my child (or child under my guardianship). This includes all necessary examinations, treatment, and any other related procedures necessary to provide chiropractic care. I understand that treatment will be based on the physician's professional judgment.

PRINT NAME

SIGNATURE OF PATIENT / PARENT OR GUARDIAN

DATE

*Back 2 Health LLC, 3985 Steve Reynolds Blvd. Ste. M-101, Norcross, GA 30093
Phone: (678) 919-1333 Fax: (404) 393-9982*

FINANCIAL RESPONSIBILITY

(Please Initial Each Statement and Sign Below to Indicate You Have Read and Understood Each One)

WAIVER OF INSURANCE BENEFITS FOR PERSONAL INJURY CASES

_____ If there is an automobile insurance policy that has "medical payment" or "PIP" coverage which can be used for my treatment, I agree that all medical payment monies from said automobile insurance company should be used to satisfy any outstanding balance with Back 2 Health LLC and check should be written directly to Back 2 Health LLC. This agreement will supersede all other agreements, contractual or otherwise, including but not limited to agreements with attorneys or other agencies or agents.

_____ I acknowledge that I am choosing not to use, or do not have, Private Health Insurance including Medicare & Medicaid. I also understand that there will be no retroactive billing to my Private Health Insurance including Medicare & Medicaid.

_____ I understand that I will sign a 3rd party or attorney lien, which is a deferment of payment, not a forgiveness of payment.

_____ I acknowledge that, should my account not be paid within thirty (30) days of the date of settlement of a personal injury claim, my account may be sent to a collection agency. I will be responsible for all attorney fees and court costs.

HEALTH INSURANCE BENEFITS

As a courtesy to our patients, we will sometimes attempt to bill your health insurance company for payment for chiropractic services that remain unpaid by alternative carriers or in circumstances where settlements are reduced or denied. Please be aware that your insurance policy is a contract between you and your insurance company. Also, be aware that some, and perhaps all, of the medical services we provide may not be covered or considered reasonable and necessary under your specific health insurance plan.

_____ All co-payments, deductibles, or patient responsibility portions are due at the time services are provided. Any amounts not covered by your insurance company are your responsibility. This includes but is not limited to; charges for office visits, administrative fees, supplies, and x-rays.

_____ I authorize all insurance payments to be made directly to Back 2 Health LLC, that would otherwise be payable to me, for chiropractic services received. If needed, I also authorize Back 2 Health LLC, to sign my name in the event a check for services rendered is made out to me or both parties and I cannot be reached. I am aware that in the event my health insurance does not pay for services rendered, I may be held financially responsible.

STATEMENT OF NON-INSURANCE

_____ I acknowledge that I am choosing not to use, or do not have, Private Health Insurance including Medicare & Medicaid. I also understand that there will be no retroactive billing to my Private Health Insurance including Medicare & Medicaid.

_____ NOT APPLICABLE

I acknowledge that I am the patient or patient's legal guardian. I understand the following:

_____ The medical bills incurred in this office are the sole responsibility of the patient or the patient's legal guardian or legal representative regardless of insurance status and/or outcome of pending litigation.

PRINT NAME _____

SIGNATURE OF PATIENT/PARENT/GUARDIAN OR LEGAL REPRESENTATIVE

DATE

*Back 2 Health LLC, 3985 Steve Reynolds Blvd. Ste. M-101, Norcross, GA 30093
Phone: (678) 919-1333 Fax: (404) 393-9982*

NOTICE OF PRIVACY PRACTICES

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

Back 2 Health LLC are required to abide by the terms of this Notice, but reserve the right to change the Notice at any time. Any change in the terms of this Notice will be effective for all PHI (Personal Health Information) that Back 2 Health LLC maintain at that time. If a change is made to this Notice, a copy of the revised Notice will be provided to all individuals receiving care at that time.

EXAMPLES OF HOW PHI MAY BE USED OR DISCLOSED BY YOUR HEALTH PLAN

The following categories describe different ways that Back 2 Health LLC may use or disclose your PHI in compliance with state and federal law. The examples of permitted uses and disclosures listed are not provided as an all inclusive list of the ways in which PHI may be used. They are provided to describe in general, the types of uses and disclosures that may be made.

Treatment, Payment and Health Care Operations

State and federal laws allow Back 2 Health LLC to use and disclose PHI for the purposes of treatment, payment, and health care operations, without your consent or authorization.

- **Treatment.** Treatment refers to the provision and coordination of health care by a doctor, hospital, or other health care provider.
- **Payment.** Payment refers to the activities of Back 2 Health LLC in collecting payment for health services provided. *Examples of uses and disclosures under this section include sharing PHI with a third party administrator for claims adjudication and payment; with insurers to determine coordination of benefits or to settle subrogation claims; providing PHI for billing, collection and payment through an attorney or insurance carrier.*
- **Health Care Operations.** Health Care Operations refers to the basic business management, planning and development, administrative and quality assurance functions necessary to operate your Health Plan. *Examples of uses and disclosures of PHI under this section include resolution of grievances and appeals, conducting quality assessment.*

Other Uses and Disclosures

Back 2 Health LLC is permitted to use or disclose your PHI for the following purposes. State and federal law requires a Health Plan to use and disclose PHI, without your authorization, in the following ways:

- To you, as the covered individual.
- To a personal representative designated by you or a personal representative designated by law such as the parent or legal guardian of a child or the surviving family members or personal representative of the estate of a deceased or incompetent individual.
- To the Secretary of Health and Human Services (HHS) or any employee of HHS as part of an investigation to determine our compliance with the HIPAA Privacy Rules.
- To a Business Associate as part of a contracted agreement to coordinate healthcare services
- In response to a court or administrative order, subpoena, discovery request, or other lawful judicial proceeding.
- As required to comply with Workers' Compensation or other similar programs established by law.

ADDITIONAL USES AND DISCLOSURES

We will obtain your written authorization before using or disclosing your PHI for purposes other than those provided for above (or as otherwise permitted or required by law). You may revoke an authorization at any time by providing written notice to the Privacy Officer for Back 2 Health LLC that you wish to revoke your authorization. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that action has already been taken in reliance on the prior authorization.

YOUR RIGHTS IN RELATION TO YOUR PROTECTED HEALTH INFORMATION

Right to Request Restrictions on Certain Uses and Disclosures

You have the right to request that Back 2 Health LLC limit its uses and disclosures of your PHI or to restrict the use or disclosure of your PHI to family members or personal representatives. Any request must be made in writing to the Privacy Officer listed in this Notice and must state the specific restriction requested and to whom that restriction would apply. We cannot agree to restrictions on uses or disclosures that are legally required, or which are necessary to provide health care services.

**Back 2 Health LLC, 3985 Steve Reynolds Blvd. Ste. M-101, Norcross, GA 30093
Phone: (678) 919-1333 Fax: (404) 393-9982**

Right to Receive Confidential Communications

You have the right to request that communications involving PHI be provided to you at an alternative location or by an alternative means of communication. Back 2 Health LLC is required to accommodate any reasonable request if the normal method of disclosure would endanger you and that danger is stated in your request. Any such request must be made in writing to the Privacy Officer listed in this Notice.

Right to Access to Your Protected Health Information

In most cases, you have the right to inspect and copy your PHI that is maintained in a designated record set. Federal law does prohibit you from having access to the following: psychotherapy notes; information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and PHI that is subject to a law that prohibits access to that information. If your request for access is denied, you may have a right to have that decision reviewed. To inspect or copy your PHI, you must submit a written request at the treating facility. Back 2 Health LLC may charge you a fee for the cost of copying, mailing, and supplies that are necessary to fulfill your request, in accordance with state and federal law.

Right to Amend Your Protected Health Information

If you feel that your PHI is incomplete or incorrect, you have the right to request that we amend it. Back 2 Health LLC may deny your request for amendment if it determines that the PHI was not created while performing health-related services, is not part of a designated record set, is not information that is available for inspection, or that the PHI is accurate and complete. If your request for amendment is declined, you have the right to have a statement of disagreement included with the PHI and Back 2 Health LLC have a right to include a rebuttal to your statement, a copy of which will be provided to you. Requests for amendment of your PHI should be directed to the Privacy Officer listed in this Notice.

Right to Receive an Accounting of Disclosures

You have the right to receive an accounting of all the disclosures of your PHI that Back 2 Health LLC have made, if any, for reasons other than disclosures for treatment, payment, and health care operations, as described above, and disclosures made to or authorized by you or your personal representative. Your right to an accounting of disclosures applies only to PHI created or maintained by Back 2 Health LLC after April 14, 2003 and cannot exceed a period of six years prior to the date of your request. Requests for an accounting of disclosures of your PHI should be directed to the Privacy Officer listed in this Notice and must specify the time period for the PHI requested.

Right to Receive a Paper Copy of this Notice of Privacy Practices

You have the right to receive a paper copy of this Notice upon request. This right applies even if you have previously agreed to accept this Notice electronically. Requests for a paper copy of this Notice should be directed to the Privacy Officer listed in this Notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions or would like additional information about Back 2 Health LLC's Privacy Practices, you may contact the Privacy Officer at contact information listed below. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer or the Secretary of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. Complaints should be filed in writing with the Privacy Officer listed in this Notice within 30 days of the occurrence. There will be no retaliation for filing a complaint.

PRIVACY CONTACT

For concerns related to your right to access, amend, or receive an accounting of disclosures or a paper copy of the Notice you may contact the Privacy Officer at:

HIPAA Privacy Officer
Back 2 Health LLC
3985 Steve Reynolds Blvd. Ste. M-101B
Norcross, GA 30093

EFFECTIVE DATE OF NOTICE: July 15, 2012
Rev. 07/2012

I have read/received a copy of this notice of privacy practices: _____
Signature and Date

Back 2 Health LLC, 3985 Steve Reynolds Blvd. Ste. M-101, Norcross, GA 30093
Phone: (678) 919-1333 Fax: (404) 393-9982

Back 2 Health LLC
3985 Steve Reynolds Blvd. Ste. M-101B
Norcross, GA 30093
Phone: (678) 919-1333 Fax: (404) 393-9982

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

The execution of this form does not authorize the release of information other than that specifically described below.
Your disclosure of the information requested on this form is voluntary. However if the information including social security number is not furnished completely and accurately, Back 2 Health LLC may be unable to comply with the request.

Patient Name _____ DOB ____/____/____

Social Security Number _____ -- _____ -- _____

The medical records and information indicated below are to be released to the following entity and its authorized representatives:

Back 2 Health LLC
Dr. Bernadette Merricks
3985 Steve Reynolds Blvd. Ste. M-101B
Norcross, GA 30093
Phone: (678) 919-1333 Fax: (404) 393-9982

By my signature below, I request and authorize (indicate name and address of organization or individual from whom the information is requested) to release personal health information as indicated:

Information Requested Includes:

_____ *all medical records* _____ *billing statements* _____ *radiology/lab reports*
_____ *intake/registration forms* _____ *other* _____

*This authorization is effective for **one (1) year** from the date signed unless revoked or terminated by the patient or patient's personal representative.*

You may revoke or terminate this authorization by submitting a written request to Back 2 Health LLC Attn: Medical Records at the address listed above.

SIGNATURE OF PATIENT, GUARDIAN OR RESPONSIBLE PARTY

DATE

*Back 2 Health LLC, 3985 Steve Reynolds Blvd. Ste. M-101, Norcross, GA 30093
Phone: (678) 919-1333 Fax: (404) 393-9982*