WELCOME TO ALIGNED 4 LIFE

Our Goals:

1. Determine the cause of your pain.
2. Reduce your pain as soon as possible
3. Reduce the long term effects of your injury.
4. To document your progress
5. Refer you to the proper specialist or diagnostic test when needed.

Communication is very important, so please feel free to ask questions. Aligned 4 Life has been in practice for For several years and can answer most questions you may have. Please ask questions!

It is very important that vou follow all of the doctor's recommendations, this will allow for optimal healing. Home activities, nutrition, making your therapy appointments and avoidance of relapses are important for complete healing to occur. Remember healing takes time, but the sooner we get you out of pain the better.

Patients are typically seen 3 times a week for 4-6 weeks until the pain is 50% improved. At the end of the 4th week your condition will be re-evaluated. Once the pain is relieved, we will work to strengthen the area to ensure long term success.

Office hours: Monday & Wednesday 9-9, Thursday 9-6, Friday 9-1

PATIENT INFORMATION

Date of Birth _____ Age _____ Social Security # _____

Last _____ First _____ Middle Initial _____

Address _____ City _____ ST _____ Zip _____

Phone (H) _____ (W)_____ (C)_____ Email_____

CONSENT FOR TREATMENT

I, the undersigned, a patient in this office hereby authorize AlignedLife and whomever they may designate as assistant(s) to administer treatment as is necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from my insurance company and that pay amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account.

Patient's Signature _____ Date _____

CONSENT FOR TREATMENT OF MINOR

I, the undersigned, hereby authorize AlignedLife and whomever they may designate as assistant(s) to administer chiropractic care as is necessary to _____ .

Patient's Signature _____ Date _____

ALIGNED 4 LIFE WELLNESS, LLC

Notice of Privacy Practices

*** 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.**

Uses and Disclosures: We will use and disclose elements of your protected health information (PHI) in the following ways:

Without your signed authorization

* Treatment (daily office notes)
* Payments (from your insurance company or yourself)
* Health care operations (descriptions of treatment you received)
* When release is required by law, including in judicial setting and to health oversight regulatory agencies and law enforcement.
* To medical examiners, corners or funeral directors to aid in identifying you or to help them in performing their duties.

Special Cases

* To contact you about appointment reminders, treatment alternatives and other health related benefits and services.
* In fundraising for ourselves.
* To the sponsor of your health plan.
* To your attorney with written and signed request.

Other

* All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your rights: You have the following right concerning you PHI:

Restrictions: To request restricted access to all or part of your PHI. To do this, you must provide the request in writing including the reason and present it to us. We are not required to grant your request.

Confidential communications: To received correspondence of confidential information by alternate means or location. To do this, it must be described in a signed written request.

Access: To inspect or receive copies of your protected health information.

Amendments: To request changes be made to your PHI. To do this, you must present us with documentation showing our records are incorrect. We are not required to grant your request.

Accounting: To receive an accounting of the disclosures by us of your PHI in the six years prior to your request. To do this, It must be provided in writing.

This notice: To get updates or reissue of this notice, at your request.

Complaints: To complain to us or the U.S. Dept. of Health & Human Services if you feel your privacy rights have been violated. To register a complaint with us, please contact your treating Doctor or contact the Office Managers. The law forbids us from taking retaliatory action against you if you complain.

Our duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy contact: For more information about our privacy practices, please contact: 404-383-1110.

How We Protect Your Private Health Information

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I consent to the use or disclosure of my protected health information by this office for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of this office. I understand that **Aligned4Life** may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my protected health information for the above states purposes. My signature on this document is evidence of this consent.

I understand I have a right to request a restriction as to how my personal health information is used or disclosed to carry out treatment, payment or health care operations at the practice. This office is not required to agree to the restrictions that I may request. However, if this office agrees to a restriction that I request, the restriction is binding.

I understand I have a right to review this office's Notice of Privacy practices prior to signing this document. This office's Notice of Privacy has been provided to me. This Notice of Privacy Practices describes the type of uses and disclosures of my protected health care information that will occur in my treatment, payment of my bills or in the performance of health care operations of this office. The Notice of Privacy Practices for this office is also provided upon request at the main administrative desk of this office. Notice of Privacy Practices also describes my rights and this office's duties with respect to my protected health information.

This office has the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting the Privacy Officer at 404-383-1110 and request a hard copy to be sent in the mail or by asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that this office or **Aligned4Life** have taken action in reliance on this consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions regarding the Privacy Policies, and all my questions have been answered fully and satisfactorily.

Patient Printed Name	Patient Signature	Date
Witness Printed Name	Witness Signature	Date

Aligned4Life

ALIGNED 4 LIFE

Verification of Non-Pregnancy

Date: _____

Name: _____

Address: _____

_____

Telephone#: _____

Date of Birth: _____

By my signature on this form, I, _____, do hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time.

Patient Signature: _____

Witness: _____