

Clinicare of Columbus, Inc.
dba (Brodwyn & Associates)

Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Name of Person Organization

Name of Person Organization

I authorize Brodwyn and Associates to:

Speak with spouse about any insurance or health information:	Yes	No
Leave messages on home voice mail:	Yes	No
Leave messages on cell phone voice mail:	Yes	No
Speak with _____ about any insurance or health information:	Yes	No

Expiration Date of Authorization

This authorization is effective through _____ unless revoked or terminated by the patient or patient's personal representative.

Patient Rights

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

If you understand and agree with all of the above policies, please sign your name below.

Patient or Legally Authorized Individual Signature _____ Date _____

Print Patient's Full Name _____ Time _____

Witness Signature _____ Date _____



Brodwyn & Associates
3624 Edgewood Rd, Suite A
Columbus, GA 31907
706-563-3370

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

I, _____, hereby instruct and direct the _____
(Claimant) (Insurance Company Name)
Insurance Company to make payment directly to:

Brodwyn & Associates
3624 Edgewood Rd
Suite A
Columbus, GA 30907

Or

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it to:

Brodwyn & Associates
3624 Edgewood Rd
Suite A
Columbus , GA 31907

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for profession services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHT AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at _____ this _____ day of _____ 20____.
(Time) (Day) (Month) (Year)

Signature of Policyholder

Witness

Signature of Claimant, if other than Policyholder

Functional Rating Index

Please choose the answer that best describes each topic.

Pain Intensity

- No Pain
- Mild Pain
- Moderate Pain
- Severe Pain
- Worst Possible Pain

Sleeping

- Perfect sleep
- Mildly disturbed sleep
- Moderately disturbed sleep
- Greatly disturbed sleep
- Totally disturbed sleep

Personal Care (washing, dressing, etc)

- No pain; No restrictions
- Mild pain; No restrictions
- Moderate pain; Need to go slowly
- Moderate pain; Need some assistance
- Severe pain; Need 100% assistance

Travel (driving, etc)

- No pain on long trips
- Mild pain on long trips
- Moderate pain on long trips
- Moderate pain on short trips
- Severe pain on short trips

Work

- Can do usual work plus unlimited extra work
- Can do usual work; no extra work
- Can do 50% of usual work
- Can do 25% or usual work
- Cannot work

Recreation

- Can do all activities
- Can do most activities
- Can do some activities
- Can do a few activities
- Cannot do any activities

Frequency of Pain

- No pain
- Occasional pain; 25% of the day
- Intermittent pain; 50% of the day
- Frequent pain; 75% of the day
- Constant pain; 100% of the day

Lifting

- No pain with heavy weight
- Increased pain with heavy weight
- Increased pain with moderate weight
- Increased pain with light weight
- Increased pain with any weight

Walking

- No pain; any distance
- Increased pain after 1 mile
- Increased pain after 1/2 mile
- Increased pain after 1/4 mile
- Increased pain with all walking

Standing

- No pain after several hours
- Increased pain after several hours
- Increased pain after 1 hour
- Increased pain after 1/2 hour
- Increased pain with any standing

Brodwyn & Associates

NEW PATIENT/PATIENT UPDATE FORM

PLEASE FILL OUT COMPLETELY

Name _____ Date _____

Address _____

City _____ State _____ Zip _____ Phone # _____

DOB _____ SS# _____ Email _____

Marital Status M S W D Primary Medical Doctor _____

Family Relative (not living with you) Name _____

Address _____ Relationship _____

City _____ State _____ Zip _____ Phone # _____

PATIENT EMPLOYMENT INFORMATION

Employer _____

Address _____

Occupation _____ Phone # _____

INSURANCE

Insurance is in whose name Self ___ Parent ___ Spouse ___ Other ___

Policy Holders Name _____ DOB _____

Address _____

Phone# _____ SS# _____

INSURED EMPLOYMENT INFORMATION

(if different)

Employer _____

Address _____

Occupation _____ Phone # _____

DEMOGRAPHICS FOR YOUR ELECTRONIC HEALTH RECORD

Preferred Language _____

Smoking Status Never Former Occasional Smoker Daily Smoker

Race White Black/Afro-American Asian Native Hawaiian or other Pacific

Ethnicity Hispanic Non-Hispanic

Dr. Jay Brodwyn
Dr. Ken Calain

Dr. Michael Haniotis
Dr. Janet Hyder

Chiropractors

3624 Edgewood Rd. Suite A
Columbus, GA 31907
706-563-3370

INFORMED CONSENT TO CHIROPRACTIC CARE

Patient Name (printed) _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

Chiropractic is a physical, hands-on branch of the healing arts. The primary treatment that a Doctor of Chiropractic uses is called an "adjustment" or a "spinal manipulation". The purpose of the adjustment is to restore normal motion to the joints of your spine. In order to perform an adjustment, your Chiropractor may use his hands or a specialized mechanical instrument. You may experience a feeling of movement during an adjustment or hear an audible "pop" or "click" similar to "cracking" your knuckles.

It is important to understand that the Doctor may have to touch, palpate, and/or maintain contact with personal areas of your body in order to properly evaluate and treat your problem. Some examples are, but not limited to, the front of shoulder or chest, ribs (front and back), lower hips, buttocks, and groin. We make every attempt to make sure you are comfortable and encourage you to discuss any apprehensions you may have with the Doctor prior to each visit.

Examination/Treatment

As a part of the examination and treatment, you are consenting to the following procedures:

palpation	radiographic studies	spinal manipulative therapy
orthopedic testing	vital signs	hot/cold therapy
basic neurological testing	postural analysis	EMS
range of motion	muscle strength testing	intersegmental traction
other: _____		

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complication including stroke. Some patients feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contradictions to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform us.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.**

I have read { } or have had read to me { } the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Brodwyn/Dr. Haniotis/Dr. Calain and Dr. Hyder have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Patient Signature

Doctor's Name (printed)

Doctor's Signature

Date: _____

Date: _____

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor, and hereby authorize **BRODWYN & ASSOCIATES** to administer treatment as it so deems necessary.

Signature of Parent or Guardian
(if a patient is a minor)

X-ray Consent and Authorization

In order for **Dr. Brodwyn and Associates** to fully evaluate your condition and to provide proper treatment, x-rays may be needed. By my signature below, I hereby authorize **Brodwyn and Associates** to perform such radiographic examination deemed necessary to diagnose and to treat my present problem.

Patient Name (printed) _____ Date _____

Patient Signature _____

Signature of Parent or Guardian (if patient is a minor) _____

For Female Patients

The radiation used in x-rays may be harmful to an unborn child/developing fetus, especially during the first trimester. To help prevent the accidental irradiation of any unrecognized pregnancy, and in accordance with national standards, we require the following information from female patients of child bearing age:

Date of your last menstrual cycle: _____

Birth control measures: _____

Is there any chance you may be pregnant? _____

I have been fully informed of the risks involved in exposure to radiation during a first trimester pregnancy and assume the responsibility for any consequences from the procedures I am about to have. I agree that I will not hold **Dr Brodwyn and Associates** responsible for any potential harm to myself or my unborn child. By signing below, I consent to the necessary x-ray procedures.

Patient Signature: _____ Date: _____

Signature of Parent or Guardian (if patient is a minor) _____