DR. MAURICE J. CYR CHIROPRACTIC PHYSICIAN

Physical Rehabilitation and Health Center
245 Stratton Road
Rutland, Vermont 05701-4621
(802) 775-6961

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT E-MAIL: _____ Date _____

NAME _____
(LAST) (FIRST) (MIDDLE)

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH ____/____/____ AGE _____ Social Security No. _____

MARITAL STATUS
SINGLE _____
MARRIED _____
DIVORCED _____
SEPARATED _____
WIDOWED _____

Employed by _____ Business Phone _____ Occupation _____

Name of Spouse _____ Occupation _____ Employed by _____
(If minor, name of parents)

Number of Children _____ Number in immediate family presently being treated in this office _____

Ages and Names of Children _____

Referred to this office by _____

Have you received Chiropractic care before? _____ Where? _____ When? _____

Is this appointment the result of an injury you sustained while on the job? Yes ____ No ____

Is this appointment the result of an auto accident? Yes ____ No ____

Have you ever had the same or similar condition? Yes ____ No ____

If yes, when? _____ Describe _____

Female: Are you pregnant? Yes ____ No ____

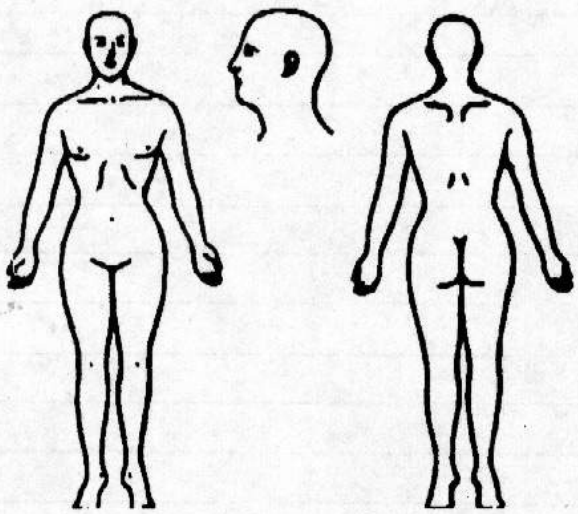
HAVE YOU EVER SUFFERED FROM:

1. Dizziness _____	5. Allergies _____	9. Asthma _____	13. Sinus Trouble _____
2. Backaches _____	6. Arthritis _____	10. Neuritis _____	14. Anemia _____
3. Heart Trouble _____	7. Headaches _____	11. Hiatial Hernia _____	15. Rheumatic Fever _____
4. Diabetes _____	8. Numbness _____	12. Nervousness _____	16. Cancer _____
Date of Last Physical Examination _____			17. Nausea _____

What operations have you had? _____ When? _____

Serious illness? _____ When? _____

Please mark your areas of pain on the figures below.



List the conditions that you are most interested in getting corrected. List in order of importance:

1. _____
2. _____
3. _____
4. _____

DO YOU:
Now take Vitamins or minerals? Yes ____ No ____

Think you may need vitamins or minerals? Yes ____ No ____

Are you wearing: Heel lifts _____ Sole Lifts _____
Inner soles _____ Arch supports _____

Please describe the principal health problem for which you came to this office: _____

_____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes _____ No _____ Constant _____ Comes and goes _____

Is this condition interfering with your: Work _____ Sleep _____ Daily Routine _____ Other _____

_____

How long has it been since you really felt good? _____

What do you believe is wrong with you? _____

Other Doctors seen for this condition _____

Have you been treated for any health conditions by a physician in the last year? Yes____ No____

Describe _____

What medications or drugs are you taking? _____

Remarks and additional information _____

_____

Regular Physician: Yes____ No____ If so whom: _____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment _____

Are you insured? Yes____ No____ Company _____

To the best of my knowledge, the above information is complete and correct. I authorize and request the performance of chiropractic services for myself or my minor child, so designated above, and give my consent to any advisable and necessary laboratory, x-ray, and treatment procedures to be administered by the attending chiropractor or by his assistants for diagnostic purposes and and chiropractic treatments.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patients Signature _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

Information taken by _____ Date _____

. . . . . **DO NOT WRITE BELOW THIS LINE** . . . . .

_____

_____

_____

_____

Patient accepted? Yes____ No____ Date_____ Doctor's Signature _____

_____

_____

_____

_____

_____

_____

_____

_____

Physical Rehabilitation and Health Center
Dr. Maurice J. Cyr

Consent for Use or Disclosure of Health Information

Our Privacy Policy

We are very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

1) We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2) We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
3) We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we may a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our policy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If we are required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Appointment Reminders

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. It is also our policy to send to our patients, appointment reminder postcards and birthday cards. By signing this form, you are giving us authorization to contact you with these reminders and information.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Printed Name	Authorized Provider Representative
Signature	Date

INFORMED CONSENT

Patient Name:_____ Date:_____

The primary treatment used by doctors of chiropractic is the spinal manipulation or adjustment. I will use that procedure to treat you. In general, spinal adjustments are safe and effective for the treatment of musculoskeletal conditions particularly for spinal related conditions.

The Nature of the chiropractic adjustment: I will use my hands or an adjusting instrument in such a way as to move your joints. This may cause an audible "click" or "pop", much as you have experienced when you "crack" your knuckles. You may feel or sense movement along with this sound.

The material risks inherent in chiropractic adjustments: As with health care procedure, there are certain complications which may arise during a chiropractic adjustment. The most frequent complication involves stiffness, or soreness following the first few days of treatment. Less frequently, complications can arise which include muscle strain or strain or separation of the ribs. Even more rare are injuries to the disc., joint dislocation, fractures, or injuries to the spinal nerves or arteries that can cause weakness or paralysis.

The Probability of those risks occurring: Fractures or dislocations are rare occurrences and generally result from some underlying weakness of the bone which are checked for during the taking of your history, physical examination or x-ray. Injuries to the arteries are extremely rare, at most a one-in-a-million chance. Since even that risk should be avoided, if possible, we also employ tests ion our examination which are designed to identify if you may be susceptible to any neurological or vascular kind of injury.

Ancillary treatment: In addition to chiropractic adjustments, I intend to also use muscle therapies in your treatment.

The availability and nature of other treatment options: All forms of treatment have inherent risks. For example, the use of prescribed or over-the-counter anti-inflammatory medication can result in stomach bleeding and in rare cases, death. Other treatments options for your condition include:

--Self-administered, over-the-counter analgesics and rest
--Medical care with prescription drugs such as muscle relaxants and pain killers
--Surgery
--Nothing

The risks and dangers attendant to remaining untreated: Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reduced mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. It is my responsibility to ask questions and have any and all questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date:_____ Signature:_____
(Guardian if a minor)

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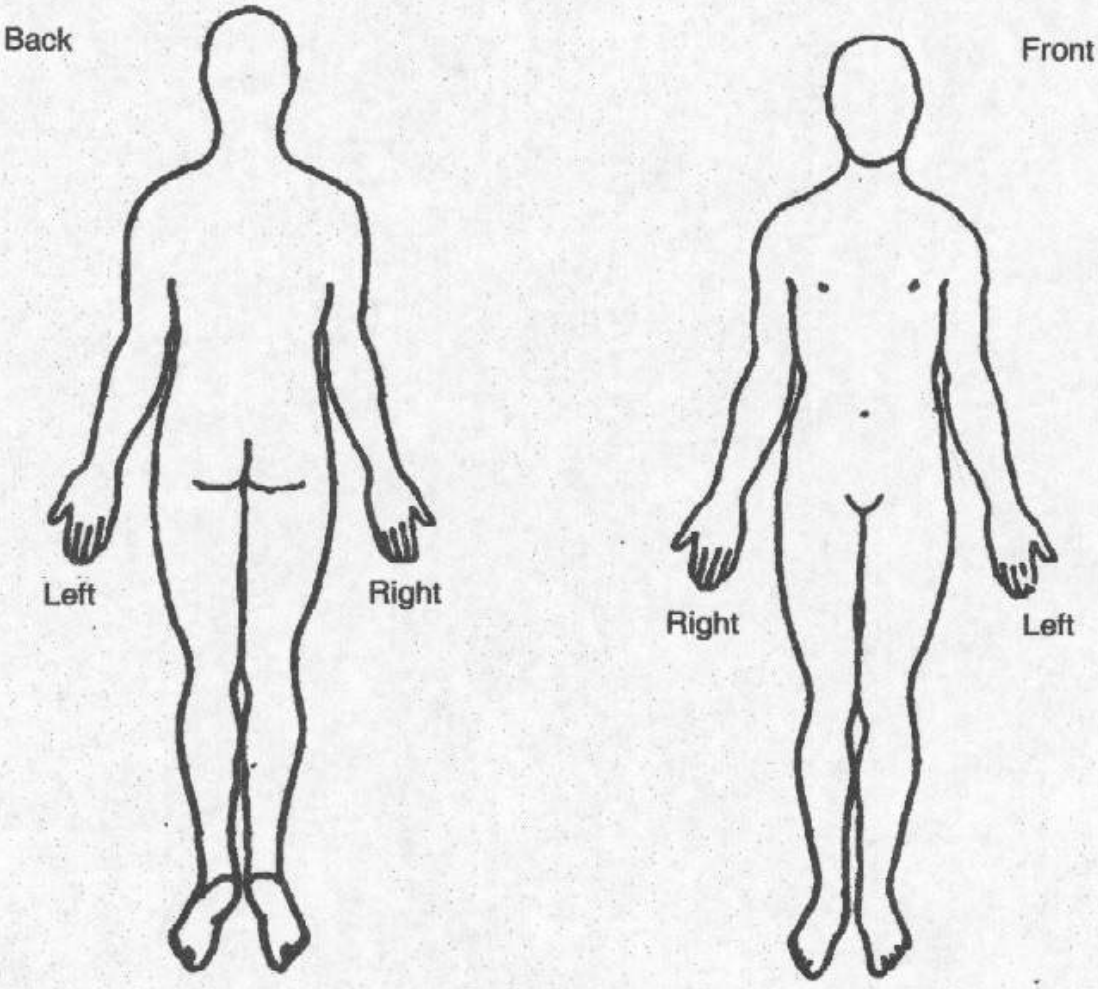
PAIN DRAWING

Date _____ Name _____

Draw location of your pain on body outlines and mark how bad it is on pain line at bottom of page.

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
^^^^	=====	oooooo	. . . . .	//////////	xxxxxx



No Pain — Pain Line → — Worst Possible Pain