Confidential Patient Health Record

Today's Date: _____/_____/_____

How did you hear about us? ( ) Close to home/work ( ) Yellow pages ( ) Drove by ( ) Insurance Plan

( ) Dr._____ ( ) Family_____

( ) Friend_____ ( ) Co-Worker_____

Personal Information

Last: _____ First: _____ Middle: _____

Date of Birth: ____/____/____ Age: _____ Sex: Male / Female Social Security #:_____-_____-_____

Primary Language: ( ) English ( ) French ( ) German ( ) Spanish ( ) Other: _____

Race: ( ) African American ( ) Asian ( ) Caucasian ( ) Hispanic ( ) Multiracial ( ) Native American ( ) Other:_____

Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced ( ) Separated

Address: _____ Apt#_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ ext. _____

Cell Phone: (_____) _____-_____ E-mail Address: _____

Spouses Name: _____

Do you have children? ( ) Yes ( ) No How many? _____

Do You Use: ( ) Alcohol ( ) Coffee ( ) Tobacco

Have you ever been a smoker? ( ) Yes ( ) No

Emergency Contact

Last: _____ First: _____ Middle: _____

Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Relationship: ( ) Spouse ( ) Relative ( ) Friend ( ) Other _____

Email Address: _____ Date of Birth: _____/_____/_____

Home Phone: (_____) _____-_____ Work Phone: (_____)_____-_____

Cell Phone: (_____) _____-_____

Employment Information

Business Name: _____

Address: _____ **Apt#**_____

City: _____ **State:** _____ **Zip:** _____ **Phone:** (_____) _____-_____

Occupation/Job Title: _____ **Job Description:** _____

Current Health Condition

Why are you here today? _____

When did this Condition BEGIN? _____/_____/_____ **Has it ever occurred before? ( ) Yes ( ) No**

Is the Condition: ( ) Auto related ( ) Job related ( ) Home Injury ( ) Slip or Fall ( ) Unknown cause

Explain: _____

Date of Accident: _____/_____/_____ **Time of Accident:** _____ **am / pm**

Condition pain STARTED on what Date: _____/_____/_____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____

_____

Do you feel your condition is: ( ) Improving ( ) Staying the same ( ) Getting Worse

Have you lost time from work? ( ) Yes ( ) No

Can you perform physical work activities: ( ) Yes ( ) No

If no, is it because of: ( ) Pain ( ) Weakness ( ) Stress

Activities of Daily Living

Please select all activities you are currently experiencing problems with:

( ) Seeing
( ) Hearing
( ) Reading
( ) Holding
( ) Walking
( ) Kneeling
( ) Lifting
( ) Sitting
( ) Sports
( ) Reclining
( ) Insomnia
( ) Loss of concentration
( ) Changes in personality

( ) Bathing
( ) Typing
( ) Pinching
( ) Stooping
( ) Bending
( ) Pushing
( ) Driving
( ) Exercising
( ) Restful sleep
( ) Using the toilet

( ) Grooming
( ) Writing
( ) Standing
( ) Squatting
( ) Twisting
( ) Pulling
( ) Riding in car
( ) Loss of sexual drive
( ) Nervous
( ) Tactile feeling

( ) Dressing
( ) Grasping
( ) Leaning
( ) Climbing
( ) Carrying
( ) Reaching
( ) Air travel
( ) Irritable
( ) Other:

Can you go to sleep without problems? ( ) Yes ( ) No

Do you awaken because of pain? ( ) Yes ( ) No

Did you have sleep problems before? ( ) Yes ( ) No

MEDICAL HISTORY

( ) None
( ) Abdominal Pain
( ) Abnormal weight gain/loss
( ) Angina
( ) Anorexia
( ) Anxiety
( ) Aortic aneurysm
( ) Arthritis
( ) Asthma
( ) Bladder infection
( ) Blood disorder
( ) Breast lumps
( ) Breast soreness
( ) Bronchitis
( ) Cancer
( ) Cardiovascular disease/ Heart attack
( ) Chest pain
( ) Chronic cough
( ) Chronic sinusitis
( ) Colitis

( ) Constipation
( ) Convulsions
( ) COPD
( ) Depression
( ) Dermatitis/Eczema/Rash
( ) Diabetes
( ) Difficulty in swallowing
( ) Dizziness
( ) Emphysema
( ) Endometriosis
( ) Epilepsy
( ) Excessive thirst
( ) Fainting
( ) Frequent urination
( ) General fatigue
( ) Gout
( ) Hand/wrist pain
( ) Headache
( ) Heartburn/Indigestion
( ) Hepatitis
( ) High cholesterol

( ) High PSA
( ) High triglycerides
( ) Hypertension
( ) Irregular menstrual flow
( ) Irritable colon
( ) Jaw pain
( ) Kidney disorders
( ) Kidney stones
( ) Liver/Gallbladder problems
( ) Loss of appetite
( ) Loss of bladder control
( ) Low back pain
( ) Lung disease
( ) Mental disease
( ) Mid back pain
( ) Muscular in-coordination
( ) Neck pain
( ) Osteoarthritis
( ) Pain in ankle/foot
( ) Pain in lower leg/knee
( ) Pain in upper arm/elbow

( ) Pain in upper leg/hip
( ) Painful urination
( ) PMS
( ) Profuse menstrual flow
( ) Prostate problems
( ) Rapid heart beat
( ) Renal Disease
( ) Rheumatoid Arthritis
( ) Scoliosis
( ) Shoulder pain
( ) Stroke
( ) Swelling/stiffness of joints
( ) Thyroid disease
( ) Tinnitus (ear noises)
( ) Tuberculosis
( ) Tumor
( ) Ulcer
( ) Visual disturbances

FAMILY HISTORY

Please select all conditions that apply to your immediate family and write corresponding letter from key at bottom of page next to the condition.

( ) None
( ) Abdominal pain
( ) Abnormal weight gain/loss
( ) Anorexia
( ) Anxiety
( ) Aortic aneurysm
( ) Arthritis
( ) Asthma
( ) Bladder infection
( ) Blood disorder
( ) Breast lumps
( ) Breast soreness
( ) Bronchitis
( ) Cancer
( ) Cardiovascular disease
( ) Chest pains
( ) Chronic cough
( ) Chronic sinusitis
( ) Colitis
( ) Constipation
( ) Convulsions
( ) COPD
( ) Depression
( ) Dermatitis/Eczema/Rash
( ) Diabetes
( ) Difficulty swallowing
( ) Dizziness
( ) _____

( ) Emphysema
( ) Endometriosis
( ) Epilepsy
( ) Excessive thirst
( ) Fainting
( ) Frequent urination
( ) General fatigue
( ) Gout
( ) Hand pain
( ) Headache
( ) Heart attack
( ) Heart disease
( ) Heartburn/Indigestion
( ) Hepatitis
( ) High cholesterol
( ) High PSA
( ) High triglycerides
( ) Hypertension
( ) Irregular menstrual flow
( ) Irritable colon
( ) Jaw pain
( ) Kidney disorders
( ) Kidney stones
( ) Liver/Gallbladder problems
( ) Loss of appetite
( ) Loss of bladder control
( ) Low back pain
( ) Lung disease

( ) Mental disease
( ) Mid back pain
( ) Muscular incoordination
( ) Neck pain
( ) Osteoarthritis
( ) Painful urination
( ) Pain in ankle/foot
( ) Pain in lower leg/knee
( ) Pain in upper arm/elbow
( ) Pain in upper leg/hip
( ) PMS
( ) Pneumonia
( ) Profuse menstrual flow
( ) Prostate problems
( ) Rapid heart beat
( ) Renal disease
( ) Rheumatoid arthritis
( ) Scoliosis
( ) Shoulder pain
( ) Stroke
( ) Swelling/stiffness of joints
( ) Thyroid disease
( ) Tinnitus (ear ringing)
( ) Tuberculosis
( ) Tumor
( ) Ulcer
( ) Visual disturbances
( ) Wrist pain

M=Mother
F=Father
B=Brother
S=Sister

MGM=Maternal Grandmother
MGF= Maternal Grandfather
PGM=Paternal Grandmother
PGF= Paternal Grandfather

Surgical History- *Please select all surgeries that you have had in the past.*

( ) None
( ) Other
( ) Abdominal Exploration
( ) Abdominoplasty
( ) Abortion
( ) ACL Reconstruction
( ) Adenoid Removal
( ) Angioplasty
( ) Appendectomy
( ) Bone Fracture
( ) Breast Lump Removal
( ) Bunion Removal
( ) Carotid Artery Surgery
( ) Cataract Surgery
( ) Cervical Spine Surgery
( ) Cholecystectomy
( ) Cosmetic Breast Surgery
( ) C-Section
( ) Facelift
( ) Gallbladder Removal
( ) Gastric Bypass
( ) Heart Bypass Surgery
( ) Heart Surgery
( ) Hemorrhoid Surgery
( ) Hernia Surgery
( ) Hip Joint Replacement
( ) Hysterectomy
( ) Kidney Transplant
( ) Knee Arthroscopy
( ) Knee Joint Replacement
( ) Knee Surgery
( ) LASIK Eye Surgery
( ) Liposuction
( ) Lumbar Spine Surgery
( ) Mastectomy
( ) Prostate Removal
( ) Rotator Cuff Surgery
( ) TMJ Surgery
( ) Tonsillectomy
( ) Vasectomy

Medications

( ) None
( ) Ambien
( ) Aspirin
( ) Daily Vitamins
( ) Synthroid
( ) Analgesics
( ) Atenolol
( ) Monopril
( ) Tylenol
( ) Advil
( ) Flexeril
( ) Motrin
( ) Vicodin
( ) Advil
( ) Diabetes Medication
( ) Blood Pressure Medication

Please list all other medications you are taking:

_____
_____
_____
_____
_____
_____
_____

ALLERGIES

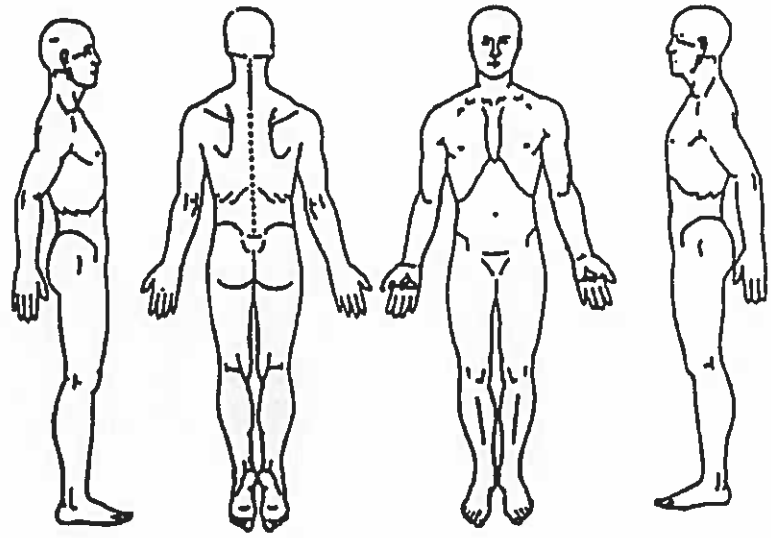
( ) None
( ) Other
( ) Adhesive tape
( ) Animal dande
( ) Anticonvulsants
( ) Barbiturates
( ) Bee, Wasp or Hornet stings
( ) Dirt
( ) Dust Mites
( ) Eggs
( ) Feathers
( ) Fish
( ) Hair spray
( ) Histamine
( ) Insecticides
( ) Insulin
( ) Iodine
( ) Latex
( ) Milk
( ) Mold
( ) Peanuts
( ) Penicillin
( ) Pets
( ) Pollen
( ) Seafood
( ) Shellfish
( ) Smoke
( ) Soy
( ) Sulfa Drugs
( ) Tobacco smoke
( ) Tree nuts
( ) Wheat
( ) List any drug allergies:

_____
_____
_____

COMPLAINTS

Please place an X on the body where you are experiencing pain or discomfort. Beside the area rate the pain grade you are having in each area 0-10 with 10 being the highest pain grade.

Rt Lt Rt Rt Lt Lt



This complaint came on:	( ) Gradually	( ) Immediately			
It is getting:	( ) Improving	( ) Same	( ) Worse		
The intensity is:	( ) Minimal	( ) Slight	( ) Moderate	( ) Severe	
The frequency is:	( ) Occasional	( ) Frequent	( ) Constant		
The pain is:	( ) Dull	( ) Sharp	( ) Aching	( ) Shooting	( ) Spasms
	( ) Throbbing	( ) Burning	( ) Numbing	( ) Tingling	( ) _____
The location is:	( ) Right	( ) Left	( ) Both sides		

Actions affecting this complaint:

Morning	( ) Brings On	( ) Aggravates	( ) Relieves
Afternoon	( ) Brings on	( ) Aggravates	( ) Relieves
Bending forward	( ) Brings On	( ) Aggravates	( ) Relieves
Bending back	( ) Brings On	( ) Aggravates	( ) Relieves
Bending left	( ) Brings On	( ) Aggravates	( ) Relieves
Bending right	( ) Brings On	( ) Aggravates	( ) Relieves
Twisting left	( ) Brings On	( ) Aggravates	( ) Relieves
Twisting right	( ) Brings On	( ) Aggravates	( ) Relieves
Coughing	( ) Brings On	( ) Aggravates	( ) Relieves
Sneezing	( ) Brings On	( ) Aggravates	( ) Relieves
Straining	( ) Brings On	( ) Aggravates	( ) Relieves
Standing	( ) Brings On	( ) Aggravates	( ) Relieves
Lifting	( ) Brings On	( ) Aggravates	( ) Relieves
Sitting	( ) Brings On	( ) Aggravates	( ) Relieves
Heat	( ) Brings On	( ) Aggravates	( ) Relieves
Cold	( ) Brings On	( ) Aggravates	( ) Relieves
Resting	( ) Brings On	( ) Aggravates	( ) Relieves
Lying down	( ) Brings On	( ) Aggravates	( ) Relieves
_____	( ) Brings On	( ) Aggravates	( ) Relieves

Radiates to: ( ) Head R L ( ) Neck R L ( ) Shoulder R L ( ) Arm R L
( ) Hand R L ( ) Hip R L ( ) Leg R L ( ) Foot R L

Woodard Wellness Group

Effective Date: September 23, 2013

NOTICE OF PRIVACY PRACTICES

I, _____, have read the attached Notice of Privacy Practices and authorize Woodard Wellness to disclose the identified information to the persons and for the purpose described herein. I understand that, by signing this document, I release Woodard Wellness from any liability and will hold Woodard Wellness harmless for any release made pursuant to this Authorization.

_____ _____

Signature of Patient or Legal Representative Date

_____

Description of Legal Representative's Authority

WOODARD WELLNESS

Effective Date: September 23, 2013

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practices describes how we may use and/or disclose your protected health information ("PHI") to carry out treatment, payment, or health care operations and for other purposes required by law. It also describes your rights to access and control any PHI that we have about you. PHI is information about you, including demographic, that may identify you and that relates to your past, present, or future physical or mental health and related services.

We are required, by law, to maintain the privacy of PHI and provide individuals with notice of our legal duties and privacy practices with respect to such information. We are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of this Notice. The new notice provisions will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with a paper copy of any revised Notice of Privacy Practices by mail or at the time of your appointment, even if you agreed to receive the Notice of Privacy Practices electronically.

Permitted Use & Disclosure of Your Protected Health Information ("PHI"):

Your physician, office staff, and others outside the office that are involved in your care may use and/or disclose your PHI for the purpose of providing health care services to you. We have listed some of the reasons why we might use or disclose your PHI and some examples of the types of uses or disclosures below. Not every use or disclosure is listed, but all of the ways that we are permitted to use and disclose information will fall into one of the following categories.

Treatment: We will use and disclose your PHI to provide and coordinate your health care and any related services. This includes the coordination or management of care with a third party that has already obtained your permission to have access to your PHI. For example, we would disclose your PHI, as necessary, to a health agency that provides care to you. In addition, we may disclose your PHI to another health care provider (e.g., a specialist or laboratory) who, at the request of your physician, is involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: We may use and disclose your PHI for billing and payment of the treatment that you received here. For example, we may use or disclose your PHI to your insurance company about a service you received so that your insurance company can pay us or reimburse you for the service. We may also ask your insurance company for prior authorization for a service to determine whether the insurance company will cover that service.

Health Care Operations: We may use and disclose your PHI to support the business activities of Woodard Wellness. These activities may include, but are not limited to, business activities, quality assessment activities, marketing, fundraising, research and the sale, transfer, merger, or consolidation of all or part of our office, related due diligence as required by law, and employee review activities. Certain direct or indirect exchanges of your PHI may result in remuneration, financial or otherwise. For example, we may use a sign-in sheet at the registration desk where you are asked to sign your name and indicate your physician. We may also call you by name in the reception when your physician is ready to see you. We may use your PHI to contact you (i.e. by telephone and/or mail) to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you or as required in the event that your PHI has been compromised.

We will share your PHI with third party "business associates" that assist in practice activities, such as billing. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI. We are prohibited from using or disclosing your genetic information for underwriting purposes, however, limited exceptions for long-term care underwriting purposes may apply.

Use & Disclosure of Your Protected Health Information ("PHI") that Requires Your Written Authorization:

You have the opportunity to agree or object to the use or disclosure of all or part of your PHI.

Your Rights: You have the right to request restrictions on certain uses and/or disclosures of your PHI. You may ask us not to use and/or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may request that information about your care be withheld from your health plan if you pay for your care out-of-pocket and in full. Please discuss any restriction you wish to request with your physician.

You may request an amendment to the use or disclosure of the PHI. Your physician may, using his/her professional judgment, determine whether the disclosure is in your best interest. If your request for an amendment is denied, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. Requested amendments and rebuttals may be placed in your medical records.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. In some circumstances, you may have a right to have this decision reviewed.

You have the right to receive an accounting of the specific information regarding the disclosures of your PHI that occurred after April 14, 2013. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, a facility directory, to family members or friends involved in your care, for notification purposes, or disclosures you have authorized. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Other uses and disclosures of your PHI will be made **ONLY** with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that Woodard Wellness has taken an action in reliance on the use or disclosure indicated in the authorization.

In the event that you need to file a complaint regarding the use and/or disclosure of your PHI or if you have any questions about the content of this Notice of Privacy Practices, or if you need to contact us about any of the information contained in this Notice of Privacy Practices, the Privacy Contact Person is:

Primary: Cookie Sanders
Address: 1245 E. Walnut St.
Carbondale, Il 62901
Phone: 618-529-4545

You may file a complaint with us or to the Secretary of the United Stated Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact Person of your complaint. We will not retaliate against you for filing a complaint.

All requests for reviews, restrictions, amendments, and alternative communications means or locations, must be in writing and state the specific requested action and name any applicable persons for which the request may pertain.

We may use and disclose your PHI in the following instances:

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.

Others Involved in Your Healthcare: We may disclose to a family member or friend that you identify, your PHI that directly relates to that person's involvement in your health care. We may use or disclose your PHI to notify or assist in notifying such persons of your location, general condition or death. We may disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to persons involved in your health care. For any persons you have identified for notification purposes as described in this Notice of Privacy Practices, you may request that any part of your PHI not be disclosed to that individual.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. We may use or disclose your PHI if your physician or another physician at Woodard Wellness is required by law to treat you and the physician has attempted to obtain your consent but is unable to do so due to substantial communication barriers, and the physician determines, using his/her professional judgment, that under the circumstances it is your intent to consent to the physician's use or disclosure or your PHI.

Psychotherapy notes (if applicable): We may use and/or disclose your psychotherapy notes for treatment, payment, or health care operations; for training purposes within our office; and as legally allowed and/or required by law.

Uses & Disclosures That Do Not Require Your Consent, Authorization or Opportunity to Object:

We may use or disclose your PHI in the following situations without your consent or authorization.

Required By Law: We may use and/or disclose your PHI to the extent that is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. We may disclose your PHI in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful process. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: Oversight agencies include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws. We may disclose your PHI to a health oversight agency for activities such as audits, investigations, and inspections.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biological product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Law Enforcement: We may also disclose your PHI for law enforcement purposes. Law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) information as it pertains to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, (6) in a medical emergency (not on the Practice's premises) and it is likely that a crime has occurred, and (7) to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Coroners, Funeral Directors, and Organ Donation: We may disclose your PHI to a coroner or medical examiner for identification purposes, for determining cause of death or for the coroner or medical examiner to perform other duties. We may also disclose PHI to a funeral director in order to permit the funeral director to carry out his/her duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaver, organ, eye or tissue donation purposes.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Military Activity and National Security: We may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for a determination by the Department of Veterans Affairs of eligibility for benefits, or (3) to foreign military authority if a member of that foreign military services. We may also disclose PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Data Security: Your records are maintained on paper charts that are kept in our office in a locked cabinet and/or room. Past patient records are kept off-site in a secure storage facility. Access to these areas is restricted to essential personnel only. We are required to notify affected individuals following a breach of secured PHI.

WOODARD WELLNESS GROUP, LLC.
PATIENT CONSENT

For use and /or disclosure of protected health information
to carry out treatment, payment and healthcare operations.

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me and obtain payment for that treatment, as well as carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent, the following appointment reminders and/or correspondence that may be used by the Practice: a) a postcard mailed to me at the address(s) provided by me; b) telephoning my home or other number(s) as provided by me and leaving a message on my answering machine, voice mail, or with the individual answering the phone; or c) e-mail correspondence to e-mail as provided by me.

4. The Practice may use and/or disclose my PHI (which includes information about my condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific operations.

5. I understand I have a right to request that the Practice restrict how my PHI is used and/or disclose to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures as described above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way I can understand.

Name of Individual (Printed)	Signature of Individual
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, or Parent)	Relationship
Date Signed _____/_____/_____	Witness

MEDICAL BENEFITS ASSIGNEMENT AND AUHORIZATION

To: Woodard Wellness Group
100 N. Glenview Drive, Suite 101
P.O. Box 1477
Carbondale, IL 62903-1477

In consideration of your understanding to treat me, I herby agree to the following:

1. I authorize the direct payment to you of any sum I now, or hereafter, owe you by any source obligated to reimburse me for the charges for your services or otherwise obligated to make payment for me or you based in whole or in part upon the charges made for your services, and I herewith grant power of attorney to you to endorse my name on any checks or drafts in payment of such services.

2. In the event my insurance carrier or health benefits payer refuses to make full Payment upon demand by you, I assign to you the right to pursue a claim, including litigation, in either your name or mine against such entity or person to secure payment for your services.

3. I understand that I am responsible for all unpaid charges.

4. A photocopy of this document is deemed as valid and binding as the original copy.

5. This agreement is irrevocable unless by mutual agreement of Dr. Brian E. Woodard and myself.

Dated this _____Day of_____, 2_____

Patient (or guardian)	Witness

Memorandum

To: Patients using eMessaging

From: Woodard Wellness Group

Date: 5/14/2014

Re: Text messages / Emails of appointment reminders

In an effort to help our patients remember their appointments at our office, we have implemented an electronic reminder system that you have asked to take advantage of at no charge to you.

Unfortunately, electronic systems are not without "bugs" and sometimes crash and do not perform as exactly as expected. Therefore, there are times when these reminder notices may not reach you in a timely matter.

Please remember that **You** are ultimately responsible for keeping your appointments. Not receiving a text or email reminder is not a valid excuse for not keeping your appointments. Kindly give us notice of 24 hours if you are unable to keep an appointment, so that another patient may use the time we have reserved for you.

If you would like to continue to use our courtesy reminder system, please sign and date below.

Thank-you for your cooperation.

Signature_____ ***Date***_____

WOODARD WELLNESS GROUP

FINANCIAL POLICY

We are committed to providing you the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our financial relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

Our office participates in several insurance plans. Each plan has its own set of rules and regulations. Most of our patients who have health or accidental insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

Patients without Insurance coverage

Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

Group or Individual Insurance

When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. You, the patient, are ultimately responsible for your bill. Since we often are given misinformation it is our suggestion that you also confirm your chiropractic coverage.

Your carriers designated co-pays are due at the end of each treatment week. In the event that your policy does not cover the cost of therapies, services, or x-rays, you will be responsible for the cost of those services performed.

We will wait on payments from your insurance company for 90 days. If reasonable attempts have been made to collect these monies and your insurance company has not paid, the bill will become your responsibility.

Referrals

If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have a referral, YOU WILL BE RESPONSIBLE FOR ALL CHARGES UP TO THE DATE OF THE REFERRAL. It is your responsibility to provide us with the referral as soon as possible.

Worker's Compensation (On-the-Job Injury)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance policy. Your employer MUST authorize your care. You will need to inform your employer of the accident and obtain an authorization form. We will also need the name and address of the carrier of their insurance, as well as any claim number assigned to your case. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or you suspend or terminate care, any fees for service are due immediately.

If your claim is disputed, notify us immediately if an attorney is representing you. Once a claim is settled or if you suspend or terminate care, any fees for service are due immediately.

Personal Injury or Automobile accidents

Please notify your auto insurance carrier of your visits to our office immediately. Notify us immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for the settlement of your claim up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for service are due immediately.

Medicare

We do accept assignment for Medicare. The only service covered by Medicare for chiropractors is the manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any fees for the non-covered services. Our office completes and files the forms for Medicare at no charge.

If you have a secondary policy, it may or may not cover your Medicare deductible and the remaining 20% of the manipulation.

I have read and understand the payment policy of Woodard Wellness Group. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Woodard Wellness Group and my insurance company. I request Woodard Wellness Group to prepare the customary forms so that I may obtain benefits. I also understand that if my insurance company does not respond within 90 days, or I suspend or terminate care, all fees are due and payable immediately.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

I understand that any and all fees related to any collection efforts on my account are my responsibility. These fees may include, but not limited to, collection agency fees, attorney fees and court fees.

I/We have read this disclosure and agree that the Lender/Creditor may contact me/us as described above.

Patient's or Guardian's Signature **Date**

Patient's Name **Patient's D.O.B.**

Witness Signature **Date**

Updated 11/2015