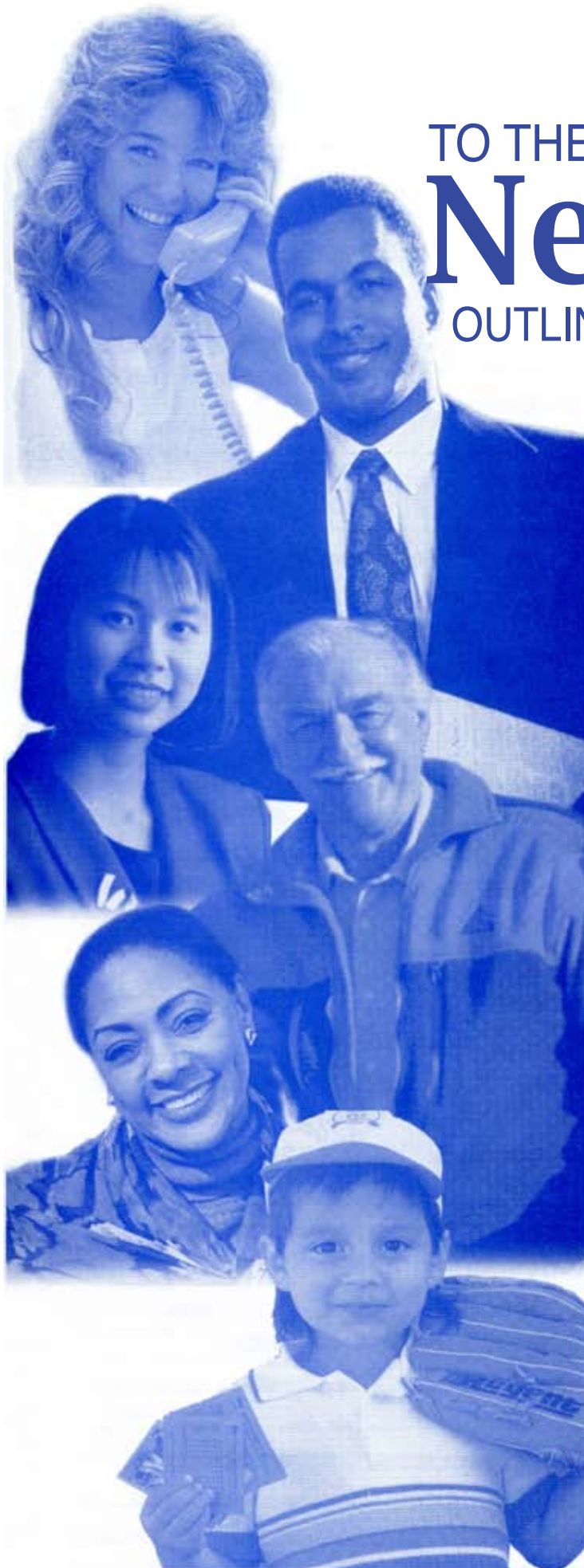




TO THE

New Patient

OUTLINE OF PROCEDURES FOR CARE



STEP ONE:

All new patients are requested to fill out this personal health history questionnaire.

STEP TWO:

A one-on-one consultation with the doctor will be done to discuss your health problems and to determine what may be the cause.

STEP THREE:

A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

STEP FOUR:

The doctor will advise you if additional laboratory tests or x-rays are needed.

STEP FIVE:

You will be given a Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of our treatment recommendations and what results can be obtained. You will also be advised concerning how our office procedures work.

STEP SIX:

If you are accepted as a patient, care will begin. Additional explanations will be given on the different types of treatments that are available in our office.

STEP SEVEN:

An estimate of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of your problem has been obtained.

STEP EIGHT:

After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

DATE _____	ID. NO. _____
------------	---------------

PERSONAL HISTORY

Name: _____ Address: _____
City: _____ State/Prov: _____ Zip/Postal Code: _____
Home Phone: _____ Birth Date: _____ Age: _____ Sex: M F
Cell/Mobile Phone: _____ E-mail Address: _____
Social Security # _____ Driver's License Number: _____
Social Insurance # _____ Circle One: Married Single Widowed Divorced Separated
Business Employer: _____ Type of Work: _____
Business Phone: _____ Spouse's Social Security # _____
Name of Spouse _____ Spouse's Social Insurance # _____
Spouse's Employer _____ Business Phone: _____
Type of Work _____ Name(s) and Age(s): _____
Referred To This Office By: _____
Name and Number of Emergency Contact: _____ Relationship: _____
Who Is Responsible For Your Bill, You and Spouse Workers' Comp. Auto Insurance Medicare Medicaid
 Personal Health Insurance (Name) _____ Health Card # _____
Insured Person's Name _____ Date of Birth _____

CURRENT HEALTH CONDITION

Unwanted Health Condition _____
Other Doctors Seen For This Condition Yes No _____ Who? _____
Type of Treatment: _____ Results: _____
When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No
Is Condition: Job Related Auto Accident Home Injury Fall Other: _____
Date of Accident: _____ Time of Accident: _____
Have You Made A Report of Your Accident To Your Employer Yes No
Drugs You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine
 Insulin Other
Do You Wear A Shoe Lift? Yes No
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH CONDITION

Please Check and Describe:
Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery
 Broken Bones Other _____
Major Accident or Falls: _____
Hospitalization (Other Than Above): _____
Previous Chiropractic Care: None Doctor's Name Approximate Date of Last Visit _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema |

INTAKE

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirsts
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

MALE/FEMALE CODE

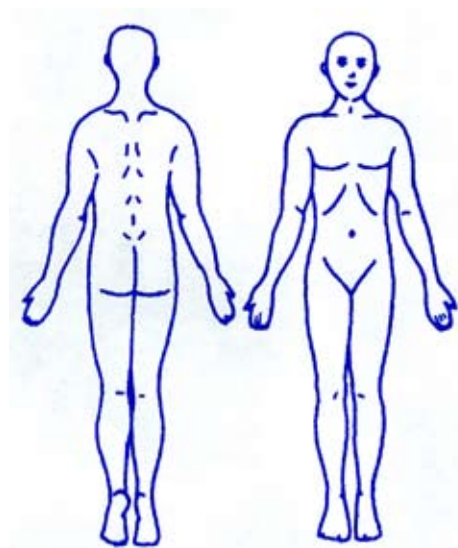
- Menstrual Irregularity
- Menstrual Crampsty
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____
- _____

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

- Yes No Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: Yes No Referred

Doctor's Signature _____

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care

Corrective Care

Check here if you want the Doctor to select the type of care appropriate for your condition

_____ Date

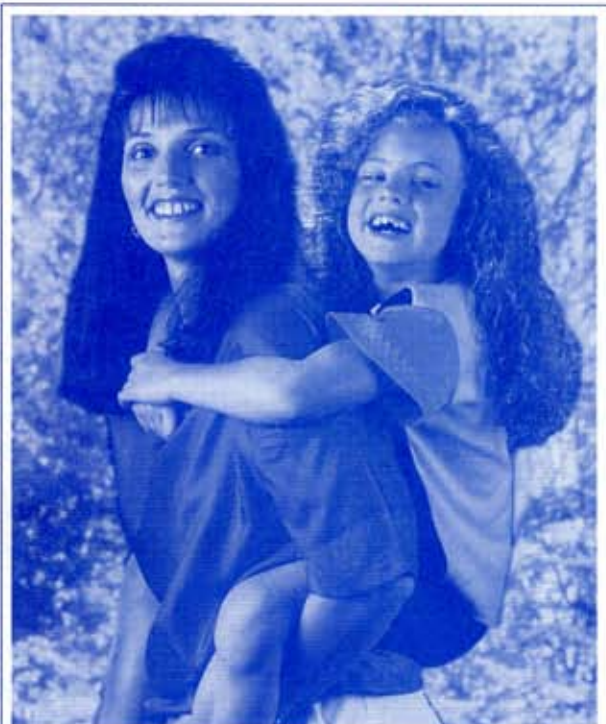
_____ Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!



Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's 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, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature _____

Date _____

Consent to Treat a Minor _____

Date _____

Guardian or Spouse's Signature of Authorizing Care _____

Date _____



Potomac Family & Sports

CHIROPRACTIC CENTER



SUMMARY

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____
3. If this is a recurrence, when was the first time you noticed this problem? _____
 How did it originally occur? _____
 Has it become worse recently? Yes ____ No ____ Same ____ Better ____ Gradually Worse ____
 If yes, when and how? _____
4. How frequent is the condition? Constant ____ Daily ____ Intermittent ____ Night Only ____
 How long does it last? All Day ____ Few Hours ____ Minutes ____
5. Are there any other conditions or symptoms that may be related to your major symptom?
 Yes ____ No ____ . If yes, describe: _____
 Are there other unrelated health problems? Yes ____ No ____ .
 If yes, describe _____
6. Describe the pain: Sharp ____ Dull ____ Numbness ____ Tingling ____ Aching ____ Burning ____
 Stabbing ____ Other _____
7. Is there anything you can do to relieve the problem? Yes ____ No ____ .
 If yes, describe _____
 If no, what have you tried to do that has not helped? _____
8. What makes the problem worse? Standing ____ Sitting ____ Lying ____ Bending ____ Lifting ____
 Twisting ____ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
 Yes ____ No ____ Uncertain ____
11. Remarks: _____

NO
SYMPTOMS

EXTREME
SYMPTOMS



Please place an "X" on the line above to indicate level of problem.

Doctor's Signature _____ Date _____

"Specializing in Family Care, Pediatrics, and Sports Medicine."



Potomac Family & Sports



CHIROPRACTIC CENTER

ASSIGNMENT, LIEN AND AUTHORIZATION INSURANCE BENEFITS AND ATTORNEY

To Whom It May Concern:

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to POTOMAC FAMILY & SPORTS CHIROPRACTIC CENTER, INC. such sums as may be due and owing to this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, no-fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me or from a settlement, judgment or verdict on my behalf as may be necessary to adequately protect this office. I hereby further give a lien to said office against any and all insurance benefits names herein, and any and all proceeds to the settlement, judgment or verdict which may be paid as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this office for their services, refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor again such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further, I authorize this office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

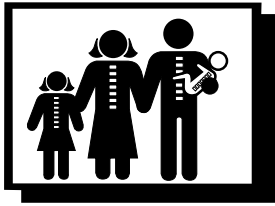
I understand that I remain personally responsible for the total amounts due this office for their services. I further understand and agree that this Assignment, Lien and Authorization do not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned office be given power of attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

I have read and understand the above policy _____ Date _____
signature

please print name here

"Specializing in Family Care, Pediatrics, and Sports Medicine."



Potomac Family & Sports

CHIROPRACTIC CENTER



August 1, 2004

Dear Patients,

Due to an increased number of missed appointments and last minute cancellations Dr. Alex McMinn of Potomac Family & Sports Chiropractic, Inc., now finds it necessary to institute a new policy.

Effective September 1, 2004, patients who fail to provide a 24-hour notice of cancellation for a scheduled appointment, continue to have chronic tardiness, or who fail to show up for scheduled appointments, will be charged a fee of \$25.00.

Implementation of this policy will benefit all of our patients who require quality attention, and will also allow us to schedule appropriately and effectively. We try hard not to over schedule so that you have time for a quality chiropractic adjustment. Patients who do not respect or value their scheduled time result in lost time for someone who really needs our services, and causes us to sometimes run behind. This is the reason for the new policy.

We do understand that situations arise, however please be mindful and respectful of other patient's time and the doctor's time. Your understanding in this matter is greatly appreciated.

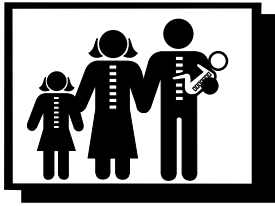
In Health,

Dr. Alex McMinn

I have read and understand the above policy _____ Date _____
signature

please print name here

“Specializing in Family Care, Pediatrics, and Sports Medicine.”



Potomac Family & Sports



CHIROPRACTIC CENTER

STATEMENT OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the Commonwealth of Virginia. This includes issues relating to your treatment, payment, and our chiropractic care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION

We will only request personal information needed to provide our standard of quality chiropractic care, implement payment activities, conduct normal chiropractic practice operations, and comply with the law. This may include your name, address, telephone number, Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

PATIENT RIGHTS

You have the right to request copies of your health care information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at POTOMAC FAMILY & SPORTS CHIROPRACTIC CENTER, INC. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

I have read and understand the above policy _____ Date _____
signature

please print name here

“Specializing in Family Care, Pediatrics, and Sports Medicine.”