



# Valley Chiropractic New Patient Medicare Registration Form

Date \_\_\_\_\_ Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Present Complaint \_\_\_\_\_

Is this condition related to auto accident or work accident:  Yes  No

<b>PATIENT PRIMARY INSURANCE INFORMATION</b>	Insurance Company _____ Member # _____ Insured's Name _____ Birthdate _____ Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
<b>SECONDARY INSURANCE INFORMATION</b>	Insurance Company _____ Member # _____ Insured's Name _____ Birthdate _____ Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
<b>PATIENT AGREEMENT</b>	<p><b>Assignment and Release</b></p> <p><i>Our office policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our office. If the account is not paid within 90 days of the date of service, and no financial arrangement has been made, you will be responsible for all expenses incurred in collecting your account. I hereby authorize payment of benefits directly to the provider of benefits due me for services rendered. I authorize the use of this signature on all my insurance submissions. I further authorize the physician and/or supplier to release any information required to process insurance claims.</i></p> <p>_____</p> <p>Signature of Insured/Guardian <span style="float: right;">Date</span></p>



# Valley Chiropractic Health Questionnaire

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Reason for visit \_\_\_\_\_

Have you been treated before for this problem:  Yes  No

If yes, by  Physician  Doctor of Chiropractic  Physical Therapist  Osteopath  Other \_\_\_\_\_

What did they recommend? \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_ Is this condition getting progressively worse?  Yes  No  Unknown

Is it constant or does it come and go? \_\_\_\_\_ Does it interfere with your  Work  Sleep  Daily routine

Recreational activities or movements that are painful to perform  Sitting  Walking  Bending  Lying down

Other \_\_\_\_\_

Your Occupation (Describe activities – sitting, lifting, etc.) \_\_\_\_\_

Non-job exercise \_\_\_\_\_ Hrs/wk

Have you ever had chiropractic care for other problems?  Yes  No  When? \_\_\_\_\_

Do you take  Muscle relaxers  Pain killers  Insulin  Birth Control Pills  Over-the-counter meds

Other prescription drugs (Please list all medication in the space at bottom of the page.)

Do you smoke? \_\_\_\_\_ If so, how much \_\_\_\_\_ How many years? \_\_\_\_\_

If stopped, how long did you smoke? \_\_\_\_\_ When did you stop? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If yes, how much/often? \_\_\_\_\_

Any history of drug use? Past or present? \_\_\_\_\_

Date of last: Physical exam \_\_\_\_\_ Spinal x-ray \_\_\_\_\_ Blood test \_\_\_\_\_

Spinal exam \_\_\_\_\_ Chest x-ray \_\_\_\_\_ Urine test \_\_\_\_\_

Dental x-ray \_\_\_\_\_ MRI, CTScan, Bone scan \_\_\_\_\_

Sleep \_\_\_\_\_ Hrs/night Do you sleep on your  Back  Side  Stomach

Age of mattress \_\_\_\_\_ or waterbed \_\_\_\_\_ Is your bed comfortable?  Yes  No

What kind of pillow do you use?  Thick  Medium  Thin  None  Support

Do you wear  Heel lifts  Shoe lifts  Arch supports  Orthotics, describe \_\_\_\_\_

**CONDITIONS** Check (✓) conditions you have or have had in the past.

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Breast lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical dependency <input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fractures <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhoea <input type="checkbox"/> Gout <input type="checkbox"/> Heart disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes <input type="checkbox"/> High cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney disease	<input type="checkbox"/> Liver disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Prostate problem <input type="checkbox"/> Prosthesis <input type="checkbox"/> Psychiatric care <input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumors, growths <input type="checkbox"/> Typhoid fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal infections <input type="checkbox"/> Venereal disease <input type="checkbox"/> Whooping cough <input type="checkbox"/> Other _____ _____
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<b>MEDICATIONS</b> List medications you are currently taking		<b>VITAMINS/HERBS/MINERALS</b>																																																																																														
<b>Allergies:</b>																																																																																																
<b>Pharmacy Name</b>		<b>Pharmacy Phone</b>																																																																																														
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<input type="checkbox"/> Bruise easily <input type="checkbox"/> Chills <input type="checkbox"/> Dental problems <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <input type="checkbox"/> Tiredness <input type="checkbox"/> Weight Gain  <b>GENITO-URINARY</b> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination	<input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood  <b>CARDOVASCULAR</b> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision – flashes <input type="checkbox"/> Vision – halos  <b>SKIN</b> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other  <b>WOMEN only</b> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other  Date of last Menstrual period _____ Date of last Pap Smear _____ Have you had a mammogram? _____ Are you pregnant? _____ Number of children _____																																																																																													
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<input type="checkbox"/> Pain in neck <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Neck weakness <input type="checkbox"/> Pinched nerve in neck <input type="checkbox"/> Neck feels out of place <input type="checkbox"/> Muscle spasm in neck <input type="checkbox"/> Grinding/popping sounds in neck  <b>SHOULDERS</b> <table style="width:100%; border:none;"> <tr> <td></td> <td style="text-align:center"><b>Right</b></td> <td style="text-align:center"><b>Left</b></td> </tr> <tr> <td><input type="checkbox"/> Pain in shoulder joint</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Pain across shoulders</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Can't raise arm</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> <tr> <td style="padding-left: 20px;"><input type="checkbox"/> Above shoulder level</td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">Over head</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Tension in shoulders</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Pinched nerve in shoulder</td> <td style="text-align:center"><input type="checkbox"/></td> <td style="text-align:center"><input type="checkbox"/></td> </tr> </table>		<b>Right</b>	<b>Left</b>	<input type="checkbox"/> Pain in shoulder joint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pain across shoulders			<input type="checkbox"/> Can't raise arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Above shoulder level			Over head			<input type="checkbox"/> Tension in shoulders			<input type="checkbox"/> Pinched nerve in shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mid-back pain <input type="checkbox"/> Mid-back stiffness <input type="checkbox"/> Pain between shoulder blades <input type="checkbox"/> Pain from front to back <input type="checkbox"/> Muscle spasms in mid-back  <b>LOW BACK</b> <input type="checkbox"/> Low back pain <input type="checkbox"/> Low back stiffness <input type="checkbox"/> Low back weakness <input type="checkbox"/> Pinched nerve in low back <input type="checkbox"/> Low back feels out of place <input type="checkbox"/> Muscle spasms in low back	<table style="width:100%; 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**I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.**

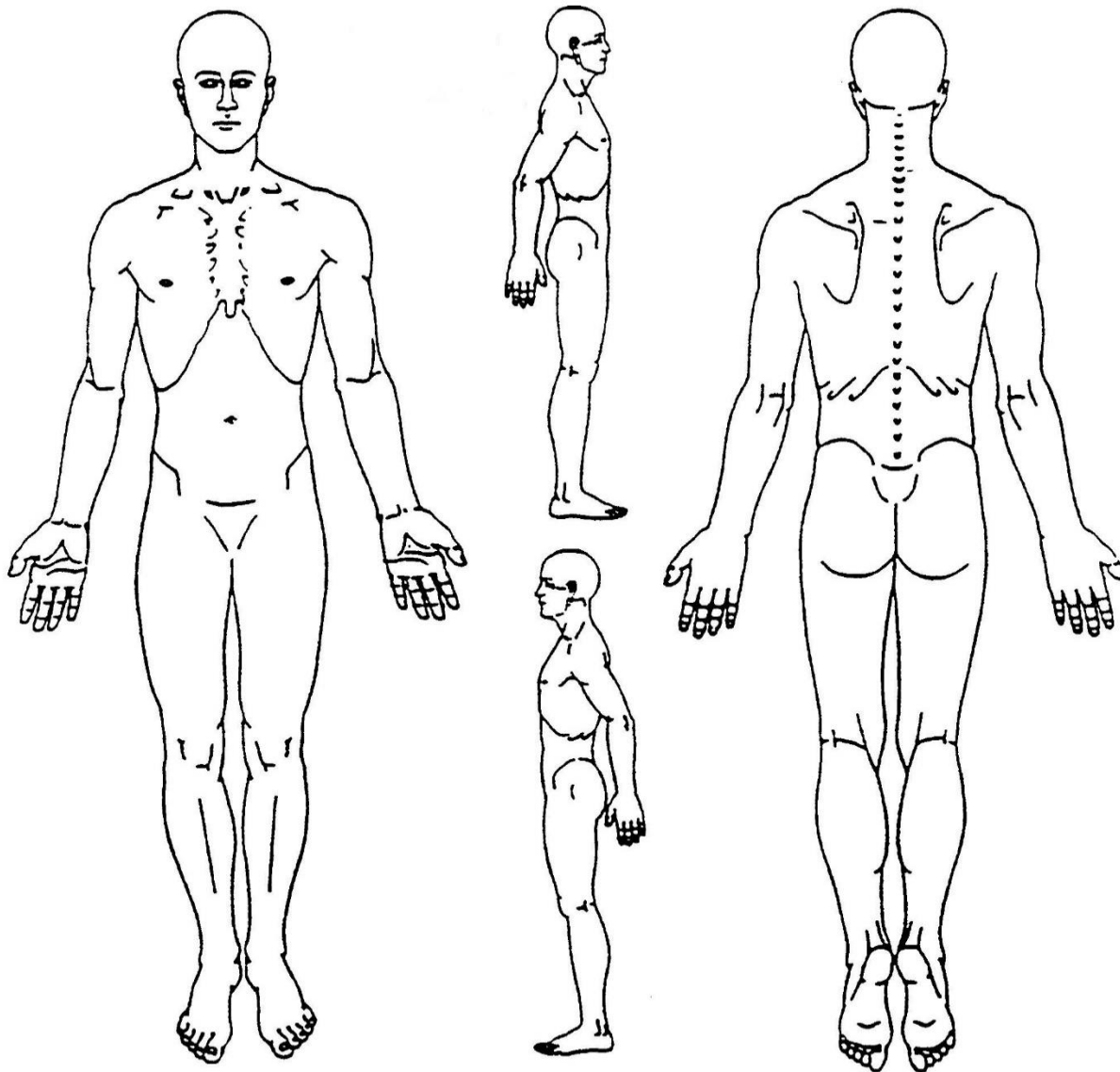
\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

PATIENT NAME: (Print) \_\_\_\_\_ Date \_\_\_\_\_

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

- D = Dull
- B = Burning
- N = Numb
- S = Stabbing/Cutting
- T = Tingling (Pins & Needles)
- C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

1. Rate the pain you have **RIGHT NOW**

NO PAIN	UNBEARABLE PAIN
<hr/>	

2. Rate your pain at its **BEST** in the past week

NO PAIN	UNBEARABLE PAIN
<hr/>	

3. Rate your **AVERAGE** pain in the past week

NO PAIN	UNBEARABLE PAIN
<hr/>	

4. Rate your **WORST** pain in the past week

NO PAIN	UNBEARABLE PAIN
<hr/>	

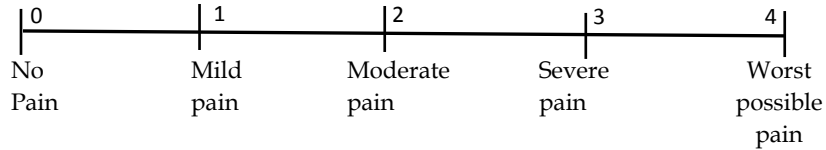
# Functional Rating Index

For use with **Neck and/or Back Problems only** In order to properly assess your condition. We must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. **For each item below, please circle which most closely describes your condition right now.**

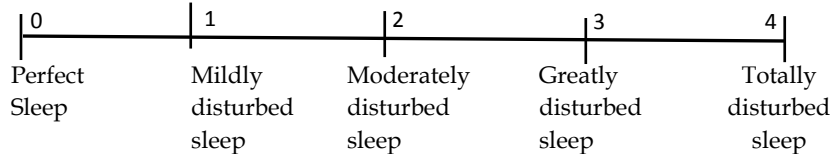
Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Total Score \_\_\_\_\_

Signature \_\_\_\_\_

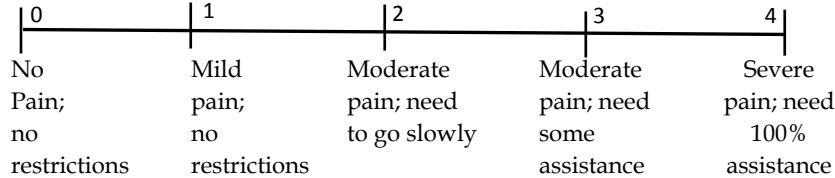
## Pain Intensity



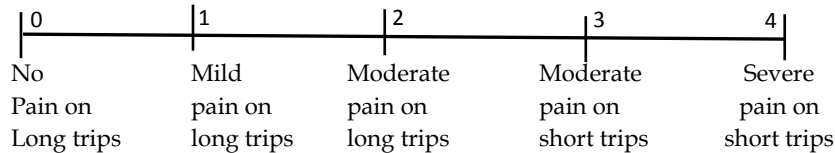
## Sleeping



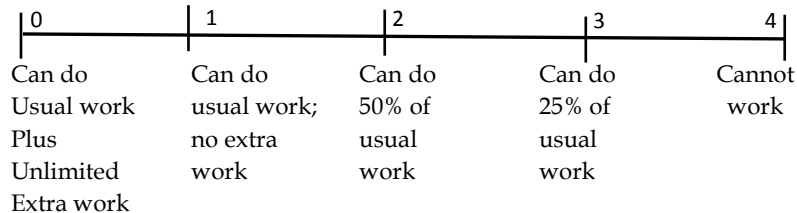
## Personal Care (washing, dressing, etc.)



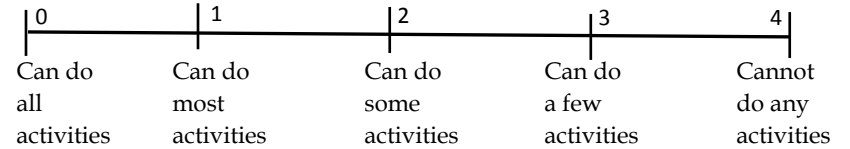
## Travel (driving, etc.)



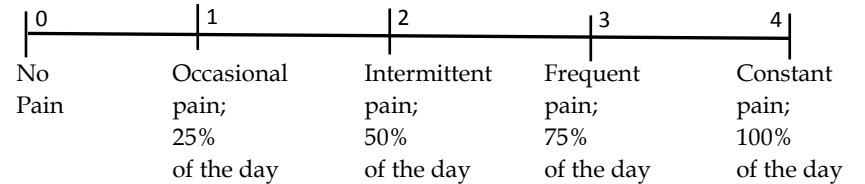
## Work



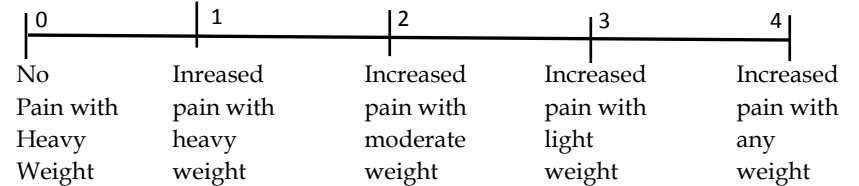
## Recreation



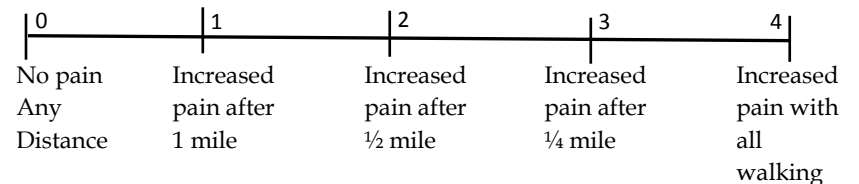
## Frequency of Pain



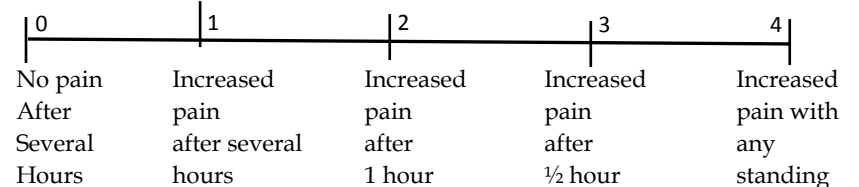
## Lifting



## Walking



## Standing



PATIENT NAME: (Print) \_\_\_\_\_ Date \_\_\_\_\_

This questionnaire can be used to quantify activity limitation and measure functional outcome for patients with an orthopedic condition. Please list any activities you are **having difficulty** with or are **unable to perform** because of your \_\_\_\_\_ problem.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**FOR DOCTOR ONLY:**

Patient specific activity scoring scheme (Point to one number):

0      1      2      3      4      5      6      7      8      9      10

Unable to  
Perform  
Activity

Able to perform  
activity at the  
same level as  
Before injury  
Or problem

(Date and Score)

Activity	Initial					
1						
2						
3						
4						
5						
6						
Additional						

**Follow-up assessments**

When I assessed you on (state previous assessment date), you told me that you had difficulty with (read all activities from list). Today do you still have difficulty with (read and have patient score each item in the list)?

**Interpretation of scores**

Total score = sum of the activity scores/number of activities

Minimum detectable change (90%CI) for average score = 2 points

Minimum detectable change (90%CI) for single activity score = 3 points



# Valley Chiropractic Financial Policy

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

## **INFORMATION:**

Prior to receiving service, you must complete our Patient Information form and any necessary Medical History and Release forms, and provide your insurance card(s) for photocopying.

## **INSURANCE:**

Insurance is a contract between you and your insurance company. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual and customary" charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.

We are authorized providers for most major insurance carriers and participate in many HMO, PPO, POS and indemnity plans. We will bill directly your primary carrier and will, if you provide us the information, bill any balance to your secondary insurance.

**Pre-authorization and referrals** – If your plan requires it, you must provide proper authorization from your primary care physician prior to receiving service. If authorization has not been obtained, we will gladly reschedule your appointment to a more convenient time.

**Self-pay** - If you do not have insurance, payment in full is expected at each visit. If this is not possible, prior to your service we will work with you to arrange a payment plan. We accept cash, checks, money orders and Visa/MasterCard.

## **LITIGATION:**

Patients involved in an auto accident, workmen's compensation or personal injury lawsuits are, as all other patients, responsible for their bills. We will, as a courtesy, send your lawyer a carbon-copy bill if you provide us with his name and address.

I have read the above policy and understand my responsibility for my account. I understand my insurance(s) may not cover this procedure and agree that I am responsible for the bill.

---

**Signature**

---

**Date**



## Informed Consent Document

***Please read prior to signing. It is important that you understand the information before you sign.***

### **The nature of the chiropractic adjustment.**

The primary treatment we use as a Doctor of Chiropractic is spinal manipulative therapy. This procedure will be comprised of either the use of my hands or a mechanical instrument upon your body in such a way as to restore motion to the joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

### **Analysis/Examination/Treatment**

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

<i>spinal manipulative therapy</i>	<i>palpation</i>	<i>vital signs</i>
<i>range of motion testing</i>	<i>orthopedic testing</i>	<i>basic neurological testing</i>
<i>muscle strength testing</i>	<i>postural analysis</i>	<i>ultrasound</i>
<i>hot/cold therapy</i>	<i>electrical muscle stimulation</i>	<i>radiographic studies</i>

### **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 complications including stroke. Some patients will feel some reasonable effort during the examination to screen for contraindications to care, however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

### **The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. 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.

**PLEASE 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. Stephen Puzio and 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 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 \_\_\_\_\_

Print Patient's Name \_\_\_\_\_

Signature \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian



## Authorization to Release Protected Health Information

Valley Chiropractic Health Center  
7460 Lancaster Pike, Suite 8  
Hockessin, DE 19707  
302-234-4045; Fax 302-234-4046

By signing below I authorize the above-named practice to use and/or disclose the following Protected Health Information (PHI):

- Medical/Chiropractic Information
- Financial Information
- Insurance Information
- Appointments

I authorize the above-named practice to disclose this information to the following:

\_\_\_\_\_  
\_\_\_\_\_

This information may be used for the purpose of provider transfer, research or at patient's request.

I understand once my information is released, it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying, in writing, the above named practice. However, a revocation will not affect any actions taken by the above-named practice prior to its receipt of the revocation.

**This authorization expires** \_\_\_\_\_.

I understand the practice will not condition treatment on whether I sign this authorization form, except in the following situations:

- If the medical information to be disclosed will result in treatment for research purposes, the practice will not provide the treatment if I am unwilling to sign this authorization form.

-If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, the practice will not provide the treatment if I am unwilling to sign this authorization form.

I will receive a copy of this completed and signed authorization form.

**Date** \_\_\_\_\_

**Signature of Patient,  
Parent, Guardian or Personal Representative** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_



# Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

Valley Chiropractic Health Center  
7460 Lancaster Pike, Suite 8  
Hockessin, DE 19707

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Valley Chiropractic Health Center may use or disclose my protected health information for treatment, payment, or health care operations, which means providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Valley Chiropractic Health Center has a detailed document called the "Notice of Privacy Practices". It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the "Notice" before signing this agreement. If I ask, Valley Chiropractic will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Valley Chiropractic Health Center to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Valley Chiropractic Health Center has taken action relying on this consent.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date \_\_\_\_\_

if signed by another party

You may obtain a copy of our Notice of Privacy Practices, including any revisions or our "Notice" at any time by contacting us at 302-234-4045.



# MEDICAL RECORDS RELEASE REQUEST

By signing this form I authorize you to release confidential health information about me by releasing a copy of my medical records, or a summary or narrative of my protected health information to:

**Valley Chiropractic Health Center – Phone 302-234-4045; Fax 302-234-4046.**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**The information you may release subject to this signed release form is as follows:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Complete Records  | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Progress Notes         |
| <input type="checkbox"/> Care Plan         | <input type="checkbox"/> Lab Reports        | <input type="checkbox"/> Radiology Reports      |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Treatment Record   | <input type="checkbox"/> Operative Reports      |
| <input type="checkbox"/> Hospital Reports  | <input type="checkbox"/> Medication Record  | <input type="checkbox"/> All of the Above _____ |
| <input type="checkbox"/> Other _____       |   |   |

Signature \_\_\_\_\_

Date \_\_\_\_\_