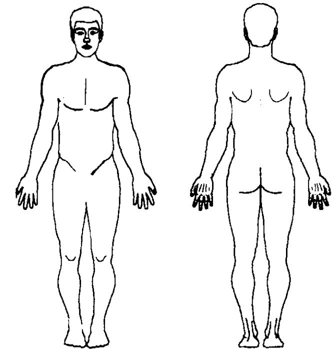
American Specialty Health Networks (ASH Networks)
P.O. Box 509001, San Diego, CA 92150-9001

INITIAL HEALTH STATUS
(Chiropractic) Fax: 877.304.2746

Patient Name: ______________________ Birthdate: ______________ Sex: M / F
Address ______________________ City ______________
State ______ Zip __________ Telephone (____) __________ Patient Primary Language ______________
Occupation: ______________ Employer: ______________ Work Phone: ______________
Address: ______________ City: ______________ State: ________ Zip: __________
Subscriber Name: ______________ Health Plan: ______________
Subscriber ID #: ______________ Group #: ______________ Spouse Name: ______________
Spouse Employer: ______________ City: ______________ State: ________ Zip: __________
Primary Care Physician Name: ______________ PCP Phone: ______________

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

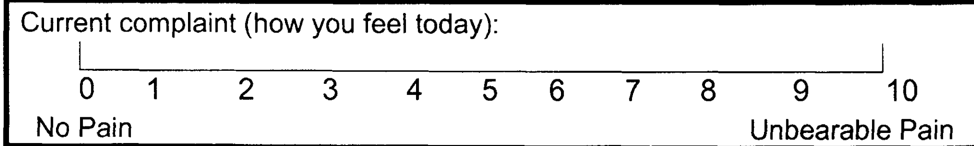


DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low back pain
☐ Other ______________________

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: ______________________
How Problem Began:



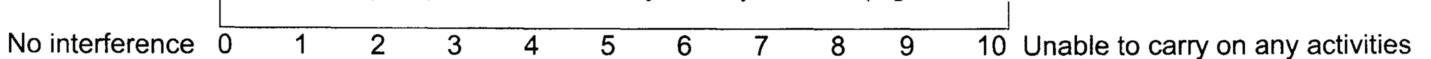
Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable Pain

How often are your symptoms present?
(Intermittent) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?



No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken: ______________ **What areas were taken?** ______________

Please check all of the following that apply to you:

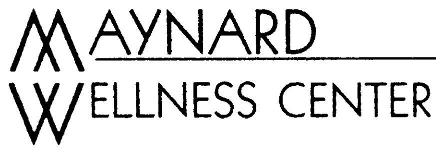
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date) ______________
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain) ______________
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (explain) ______________

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks __________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries ______________
☐ Medications: ______________

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician, if necessary.

Patient Signature: ______________________ **Date:** ______________



Dr. Curtis P. Maynard, D.C.
Dr. Kevin B. Turley, D.C.
Dr. George LeMasters, M.D.

First Name________________ MI_____ Date of Birth_____/_____/________ Sex: M F

Last Name________________ Social Security Number________________

Address________________ Marital Status________________

City________________ Home Phone________________

State________ Zip________ Work Phone________________

E-mail________________ Cell Phone________________

Employer________________________________

Primary Care Physician________________________________

Referred By________________________________

Emergency Contact (Not Living With You)

Name________________ Home Phone________________

Relationship________________ Work Phone________________

Insured (primary card holder, if not patient)

Name________________ Relationship________________

Address________________ Date of Birth________________

City________________ Home Phone________________

State________ Zip________ Work Phone________________

Social Security Number________________________________

Primary Insurance Information

Ins. Company________________ ID#________________

Address________________ Group #________________

City________________ State________ Zip________

Secondary Insurance Information

Ins. Company________________ ID#________________

Address________________ Group #________________

City________________ State________ Zip________

1920 North Scottsdale Road ✦ Scottsdale, Arizona 85257 ✦ (480) 994-0072 ✦ Fax (480) 994-8527

MAYNARD
WELLNESS CENTER

Dr. Curtis P. Maynard, D.C.
Dr. Kevin B. Turley, D.C.
Dr. George LeMasters, M.D.

ADDITIONAL INFORMATION

ARE YOU OR YOUR SPOUSE CURRENTLY EMPLOYED? [ ]YES [ ]NO

IS THIS VISIT DUE TO A WORK-RELATED INJURY? [ ]YES [ ]NO

DO YOU HAVE A LIVING WILL? [ ]YES [ ]NO

MEDICAL RECORDS

In regards to medical records release, we require the patient to sign a Release of Records Form before records are released. In the concern of quality of care and quality control, we require these records be released directly to another physician of the patient's choice. Medical records will not be released to be hand carried by the patient, the patient's family members or friends.

CONSENT FOR TREATMENT

I or my representative, recognizing the need for care, consent to any and all services as ordered by my physician, including, but not limited to; laboratory tests, medical or surgical treatment, examination, and other services rendered under the specific instructions of my physician.

INSURANCE AUTHORIZATION & ASSIGNMENT

I authorize and request payments under my medical insurance programs be made directly to the above provider for any services furnished to me. I also authorize the provider to release any information necessary to facilitate payment of claims. I further permit copoes of this authorization to be used in place of the original.

FINANCIAL POLICY

Payment is due at the time of service unless prior arrangements have been made with the business office.

I HEREBY AGREE TO PAY FOR SERVICES RENDERED AS AND WHEN CHARGES ARE INCURRED. IN THE EVENT OF DEFAULT, I WILL BE REQUIRED TO PAY LEGAL INTEREST ON MY DEBT ALONG WITH COLLECTION COSTS (30% OF THE DEBT) AND REASONABLE ATTORNEY FEES AS MAY BE REQUIRED TO COLLECT ON MY ACCOUNT.

SIGNATURE____**DATE**____________________

WITNESS____________

1920 North Scottsdale Road ✦ Scottsdale, Arizona 85257 ✦ (480) 994-0072 ✦ Fax (480) 994-8527

CURTIS P. MAYNARD, D.C.
KEVIN B. TURLEY, D.C.
GEORGE S. LeMASTERS, M.D.
1920 N. SCOTTSDALE ROAD
SCOTTSDALE, AZ. 85257
(480) 994-0072

"ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES"

I, hereby, confirm that I have received a copy of Curtis P. Maynard, D.C., Kevin B. Turley, D.C. and George S. LeMasters, M.D.'s **NOTICE OF PRIVACY PRACTICES.** I understand that it is my responsibility to familiarize myself with the contents of this Notice.

________________________ __________ __________________________

Patient/Guardian Signature Date Patient/Guardian Name-Please Print

CURTIS P. MAYNARD, D.C.
KEVIN B. TURLEY, D.C.
GEORGE S. LeMASTERS, M.D.
1920 N. SCOTTSDALE ROAD
SCOTTSDALE, AZ. 85257
480) 994-0072

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and accountability Act of 1996 (HIPPA)

THIS NOTICE DESCRIBED HOW MEDICAL INFORMATION ABOUT YOU AS A PATIENT OF THESE PRACTICES MAY BE USED AND DISCLOSED, AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY!

A. OUR COMMITMENT TO YOUR PRIVACY.

Curtis P. Maynard, D. C., Kevin B. Turley, D.C. and George S. LeMasters, M.D. are dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In our interactions with you as a patient, we will create information and records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of any health information that identifies you, and to provide you with this notice of our legal duties and the Privacy practices we maintain with respect to your IIHI. We are also required by law to act in accordance with the terms of our Notice of Privacy Practices in effect at any time. We recognize the complexity of these laws, but we are required to provide you with the following information:

(i) How we may use and disclose your IIHI
(ii) Your privacy rights with respect to your IIHI
(iii) Our obligation with respect to the use and disclosure of your IIHI

The terms of this Notice apply to all records containing your IIHI that are created or maintained by Dr. Maynard and Dr. LeMasters. We reserve the right to revise or amend this Notice of Privacy Practices at any time in accordance with State and Federal laws. Any revisions or amendments of this Notice shall be effective for all your records generated or maintained by our Practice in the past, and for any records that we may create or maintain in the future. We shall post a copy of the current version of this Notice in our patient waiting area. You may request a copy of this Notice at any time.

B. THE LAW PERMITS US TO USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

1. Treatment. We may use your IIHI to treat you. For example, we ask you to undergo laboratory tests (e.g. blood or urine tests) or x-rays and use the results of such tests to arrive at a diagnosis. Dr. LeMasters may use your IIHI to write prescriptions for you and disclose your IIHI to a pharmacist when we order a prescription for you. Any of the individuals who work for our Practice, including but not limited to the doctors, may use or disclose your IIHI in order to treat you, or to assist others in treating you. In addition, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
2. Payment. We may use and disclose your IIHI in order to bill and collect payment for any services and items we provide to you. For example, we may contact your health insurer to verify that you are eligible for benefits and what range of benefits is covered; we may provide your insure with details regarding your diagnosis and treatment to determine whether or not your insurer will cover, or pay for, such treatment. We may also use or disclose your IIHI to obtain payment for services rendered from third parties that may be responsible for such costs, for instance, family members. Further, we may use your IIHI to bill you directly for services and items.
3. Healthcare Operations. We may use and disclose your IIHI to operate the business aspects of our Practice. For example, we may use and disclose your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for the Practice.
4. Appointment Reminders. We may use and disclose your IIHI to contact you and remind you of an appointment, or to change an appointment.

5. Treatment Options. We may use and disclose your IIHI to inform you of potential treatments options or alternatives.
6. Health-Related Benefits and Services. We may use and disclose your IIHI to inform you of health-related benefits or services that may be of benefit to you.
7. Release of Information to Family/Friends. We may disclose your IIHI to a family member or a friend who is involved in your care.
8. Disclosure Required by Law. We shall use and disclose your IIHI when we are required to do so by Federal, State or local law.

C. USE AND DISCLOSURE OF YOUR IIHI UNDER CERTAIN SPECIAL CIRCUMSTANCES.
1. Public Health Risks. We may disclose your IIHI to public health authorities authorized by law to collect information for purposes such as:

- **a)** Maintain vital records such as births and deaths.
- **b)** Reporting abuse or neglect.
- **c)** Preventing or controlling disease, injury or disability.
- **d)** Notification regarding potential exposure to a communicable disease.
- **e)** Notification regarding a potential risk for spreading or contracting a communicable disease or condition.
- **f)** Reporting reactions to drugs, or problems with products or devices.
- **g)** Notification of individuals of a recall of products or devices used by such individuals.
- **h)** Notification of appropriate government agencies and authorities regarding the potential abuse or neglect of adult patients as required or authorized by law.
- **i)** Notification of employers under limited circumstances with respect to workplace injury, illness or medical surveillance.

2. Health Oversight Activities. We may disclose your IIHI to a health oversight agency for activities authorized by applicable law. Health oversight activities include, without limitation, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal proceedings and actions, and other activities necessary for the government to monitor government programs, compliance with civil rights laws and the healthcare system in general.
3. Lawsuits and Similar Proceedings. We may use and disclose your IIHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We may also disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in a dispute, but only after having made an effort to inform you of the request, or to obtain a court or administrative order protecting the information requested.
4. Law Enforcement. We may release your IIHI if asked to do so by a law enforcement official:

- **a)** Regarding a crime victim in certain circumstances, if we are unable to obtain the IIHI's owner's agreement.
- **b)** Concerning a death we believe has resulted from criminal activity.
- **c)** Regarding criminal conduct at our office.
- **d)** In response to a warrant, summons, subpoena, court order, or similar legal process.
- **e)** To identify or locate a suspect, material witness, fugitive or missing person.
- **f)** In an emergency to report a crime, including the location of victim(s) of the crime, or the description, identity and location of the perpetrator.

5. Deceased Patients. We may release your IIHI to a medical examiner or coroner to identify a deceased individual, or to determine the cause of death. If necessary, we may also release IHHI to funeral directors in order to permit them to carry out their obligations n a safe a proper manner.
6. Research. We may use and disclose your IIHI for research purposes in certain limited circumstances. We shall obtain your written authorization to use your IIHI for research purposes "except when":

- **a)** our use or disclosure was approved by an Institutional Review Board

or a Privacy Board;

b) we obtain the oral or written agreement of a researcher that (i) the information sought is necessary for the research study; (ii) the use or disclosure of your IIHI is only for research, and (iii) the researcher not remove any of your IIHI from our Practice;

c) the IIHI sought by the researcher only relates to decedents, and the researcher agrees orally or in writing that the use or disclosure is necessary for the research and, upon our request, to provide us with proof of death prior to access to the IIHI of the decedents.

7. Serious Threats to Health and Safety. We may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of others, or the public. Under these circumstances we shall make disclosures only to persons or organizations capable of preventing or eliminating the threat.

8. Military. We may disclose your IIHI if you are a member of US or foreign military forces (including veterans) and if we are required to do so by the appropriate authorities.

9. National Security. We may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We may also disclose your IIHI to federal officials or foreign heads of state, or to conduct investigations.

10. Inmates. We may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or in the custody of a law enforcement official. Disclosure shall be for the following purposes:

a) for the correctional institution to provide healthcare services to you;

b) for the safety and security of the institution;

c) to protect your health and safety, or the health and safety of others.

11. Workers Compensation. We may disclose your IIHI for Workers Compensation and similar programs.

D. YOUR RIGHTS WITH RESPECT TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

1. Confidential Communications. You have the right to request that our Practice communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may ask that we contact you at home rather than at work. In order to request a certain type of communication, you must make a written request to the Privacy Officers for Curtis P. Maynard, D.C. Kevin B. Turley,D.C. and George S. LeMasters, M.D. The Privacy Officer information will be included at the end of this Notice. Your must specify the requested method of communication, or the location where you wish to be contacted. We willaccommodate "reasonable" requests. You are not required to state a reason for your request.

2. Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment, or our healthcare operations. You also have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care, such as family members and friends. "We are not required to agree to your request", however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the Privacy Officer for Curtis P. Maynard, D.C. or George S. LeMasters, M.D. Your request must describe in a clear and concise manner the information you wish to restrict, whether you are requesting to limit our use, disclosure, or both and to whom you want the restrictions to apply. A form entitled REQUEST TO LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION is available upon request from the Privacy Officers.

3. Inspection and Copies. You have the right to inspect and obtain a copy of your IIHI that may be used to make decisions about you, including patient medical records and billing records, but excluding psychotherapy records, if any. You must submit a request in writing to the Privacy Officer for Curtis P. Maynard, D. C. or George S. LeMasters, M.D. in order to inspect and/or obtain a copy of your IIHI. We charge a per-page fee to defray the cost equipment use, labor and supplies plus, if requested to mail the copies, the actual postage required. The amount of the per-page charge may be obtained from the Privacy Officer. A form entitled REQUEST TO INSPECT AND/OR COPY PROTECTED HEALTH

INFORMATION is available, upon request, from the Privacy Officer. We may deny your request to inspect and/or copy your IIHI under certain limited circumstances; you have the right, however, to request a review of our denial. In that event, another licensed healthcare professional chosen by us shall conduct the review.

4. Amendment. You have the right to ask us to amend your IIHI if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is maintained by or for our Practice. To request an amendment, your request must be made in writing to the Privacy Officer for Curtis P. Maynard, D.C. or George S. LeMasters, M.D. You must provide us with a reason that supports your request for an amendment. We shall deny your request for an amendment if you fail to submit your request and the reason supporting your request in writing. We may also deny your request if you ask us to amend information that is, in our opinion:

a) accurate and complete
b) not part of the IIHI maintained by or for the Practice
c) not part of the IIHI you would be permitted to inspect and copy
d) not created by our Practice, unless the individual or entity that created the information is not available to amend the information.

A form entitled REQUEST FOR CORRECTION/AMENDMENT OF PROTECTED HEALTH INFORMATION is available upon request from the Privacy Officers.

5. Accounting of Disclosures. All of our patients have a right to request an accounting of disclosures. An accounting of disclosures is a listing of certain, non-routine disclosures of your IIHI made by our Practice "not" for treatment, payment or operations purposes. The use of your IIHI for routine patient care in our Practice does not have to be documented. Examples of routine use of your IIHI are: one of the doctors discussing your care with the doctor's assistant or billing staff using your IIHI to file an insurance claim on your behalf. In order to obtain an accounting of disclosures you must submit your request in writing to the
Privacy Officer for Curtis P. Maynard, D. C. or George S. LeMasters, M.D. A form entitled REQUEST FOR AN ACCOUNTING OF CERTAIN DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR NON-TPO PURPOSES is available upon request from the Privacy Officers. All requests for an accounting of disclosures must state a time period that may not be longer than 6 years from the date of disclosure and may not include dates prior to 14 April, 2003. The first list you request within a 12-month period is free of charge, but we shall charge for each additional list within a 12-month period. We shall inform you of the cost for such additional lists and you may withdraw your request if you wish.

6. Right to a Paper Copy of this Notice. You are entitled to receive a copy of this Notice of Privacy Practices.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our Practice, or with the Secretary of the Department of Health and Human Services. To file a complaint with our Practice contact the Privacy Officers. All complaints must be submitted in writing. A form entitled PATIENT COMPLAINT FORM is available upon request from the Privacy Officers. You will not be penalized for filing a complaint.

8. Right to Authorize Other Uses and Disclosures. We shall seek to obtain your written authorization for uses and disclosures that are not identified by this Notice or authorized by applicable law. Any authorization you provide us regarding other use or disclosure of your IIHI may be revoked by you at any time "in writing". Upon revocation of your authorization, we shall no longer use or disclose your IIHI for the purposes described in the authorization. Please note that we are required by law to retain records of your care. The Privacy Officer information for Curtis P. Maynard, D. C., Kevin B. Turley, D.C. and George S. LeMasters is as follows:

Curtis P. Maynard, D. C., Kevin B.Turley, D.C.
ATTN: Valerie, Privacy Officer
George S. LeMasters, M.D.
ATTN: Colleen, Privacy Officer
1920 N. Scottsdale Road
Scottsdale, AZ. 85257
(480) 994-0072