PETER BOWER, M.D.
AND ASSOCIATES

1415 Rolkin Court, Suite 301

Charlottesville VA 22911

Ph (434)964-0159 F(434)978-1667

Today's date_____

Name: _____

Date of Birth: _____ Social Security #_____

Male _____ Female_____ Non-binary _____Other _____ Prefer not to specify_____

Mailing Address: _____

City, State, Zip: _____

Home Phone: _____ Cell phone: _____ Work Phone:_____

Email Address: _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Primary Care Physician: _____

Pharmacy_____

May we contact your PCP regarding your treatment? ____Yes _____No

I the undersigned hereby authorize the staff of this center to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Furthermore, I authorize assignment of my insurance rights and benefits to be directed to the provider and also authorize the release of such information as is needed to process insurance claims. I also agree that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment statement as an original. This shall remain in effect until revoked by me in writing.

_____ _____

Signature Date

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HIPAA NOTICE of PRIVACY PRACTICE

We are required by law to maintain the privacy of your protected health information (PHI). This notice applies to all records of the health care and services you at this fascility. This notice will tell you about the ways in which we may use and disclose your PHI. This notice also describes your rights and certain obligations we have regarding the use and disclosure of your PHI.

We are required by law to:

* make sure that your PHI is kept private;
* give you this notice of our legal duties and privacy practices with respect to your PHI;
* follow the terms of this notice as long as it is currently in effect. If we revise this notice, we will follow the terms of the revised notice as long as it is currently in effect;
* train our personnel concerning privacy and confidentiality; and
* mitigate (lessen the harm of) any breach of privacy/confidentiality.

How We May Use and Disclose Information about You

The following categories (listed in bold-face print, below) describe different ways that we use and disclose your protected health information (PHI). For each category of uses or disclosures we will explain what we mean and give you some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information fall within the categories below.

For Treatment. We are permitted to use and disclose your PHI to doctors, nurses, technicians, or other personnel who are involved in taking care of you.

For Payment. We are permitted to use and disclose your PHI so that the treatment and services you receive may be billed to (and payment may be collected from) your insurance company or a third party. We also may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

To Business Associates for Treatment, Payment and Health Care Operations. We are permitted to disclose your PHI to our business associates in order to carry out treatment, payment or health care operations. For example, we may disclose your PHI to a company we hire to bill insurance companies on our behalf to help us obtain payment for the health care services we provide.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care.

Special Situations

As Required By Law. We will disclose your PHI when required to do so by federal, state, or local law.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to law enforcement in order to help prevent the threat.

Workers' Compensation. We may release your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

When Your Authorization is Required

Uses or disclosures of your PHI for other purposes or activities not listed above will be made only with your written authorization (permission). If you provide us authorization to use or disclose your PHI, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your PHI for

the reasons covered by your written permission. However, we are unable to take back any disclosures we have already made with your permission.

Your Rights

You have the following rights regarding the PHI we maintain about you.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Inspect and Receive a Copy. You have the right to inspect and receive a copy of PHI that may be used to make decisions about your care.

If you request a copy of your PHI, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect or receive a copy in certain very limited circumstances. If you are denied access to PHI, we will notify you in writing, and you may request that the denial be reviewed.

Right to Amend. If you believe that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by this clinic. You must include a reason that supports your request.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Date

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Appointment Cancellation Policy

We require a 24 hour notice for appointment cancellations. There will be a $75.00 charge for all missed appointments and cancellations made under 24 hours from your scheduled appointment. This includes new patient appointments. You will be billed directly for any missed or cancelled appointment.

It is your responsibility to remember your appointment. Email reminders and reminder phone calls are merely a courtesy. You are still responsible for keeping your appointment regardless if you receive a reminder or not.

If you should need to cancel after hours, please leave your cancellation on the answering machine. The date and time of your call will be recorded.

Certainly, there are emergency circumstances that make notification impossible. In that case, please contact us as soon as possible to avoid the no show fee. Thank you for your cooperation.

Peter J. Bower, M.D.
Diana H. Bower, F.N.P.
Leslie Chisnell, R.N., L.M.T.

Signature_____

Print_____

Date_____

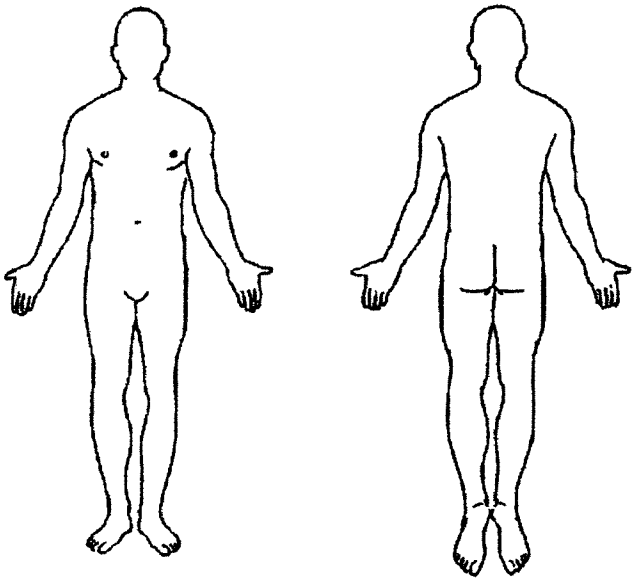
INTAKE QUESTIONNAIRE

OFFICE USE ONLY: Provider_____ Visit date_____

Name: _____

Please shade the place(s) that hurt. Draw an arrow pointing to the worst spot.

Front *Back*



When did your pain start?_____

How bad has your pain been this past week (check one)?

☐ *"Minimal.* Pain is hardly noticeable."
☐ *"Mild.* Low level of pain. Only aware of my pain when I think about it."
☐ *"Uncomfortable.* Pain bothers me but I can ignore it most of the time."
☐ *"Moderate.* Constantly aware of pain but can continue most daily activities."
☐ *"Distracting.* Think about pain most of the time. Can't do some daily activities due to pain."
☐ *"Distressing.* Think about pain all the time. Give up many activities because of pain."
☐ *"Unmanageable.* Pain all the time prevents most activities. (Often miss work due to pain.)"
☐ *"Intense.* Pain is severe. Hard to think of anything else. Talking and listening are difficult."
☐ *"Severe.* Pain is all I can think about. Can barely talk or move due to pain."

My pain is worse when I: _____

My pain is better when I: _____

Circle any of the following that describe your pain:

Aching Burning Constant Dull Intermittent Sharp Shooting Stabbing Throbbing Other: _____

Is there any: (check all that apply)?

☐ *Increased pain with cough or sneeze*
☐ *Numbness or tingling*
☐ *Shortness of breath*
☐ *Pain with urination or pain with sexual activity*
☐ *Change in bowel or bladder function*
☐ *Joint swelling*
☐ *Swelling or redness of your eyes*
☐ *Fevers, chills or sweats*
☐ *Weakness*
☐ *Unexplained weight loss*
☐ *Recurrent rashes on the skin or hypersensitivity of the skin*

What treatments have you tried for your pain:
Physical Therapy Trigger point injections Epidural steroid injections Chiropractic Massage Acupuncture Medications Other:_____

What evaluation(s) (laboratory, radiology) have you had to date for your condition:

_____

_____

Please list past illnesses or injuries _____

_____

_____

Please list your current medications _____

_____

Please list your surgeries _____

_____

Are any of your relatives afflicted with a disease that affects joints, nerves or muscles? Please list_____

Are you currently on any kind of regular exercise program? Please describe_____

_____

Do you smoke? _____ **Do you drink alcohol?** _____

What is your occupation?_____

Whom do you live with?_____