Print Name ________________________________

PATIENT INFORMATION

CASE HISTORY

PATIENT # ____________________

Name: ________________________________ Date: ________________________________
Address: ________________________________ City: __________ State_____ Zip: ______________
Home Phone: ____________________ Cell Phone: ____________________ Email: ____________________
Age: ____________________ Social Security: ____________________ Birth Date: ____________________
Marital Status: M○ S○ W○ D○ (select one) Who referred you to our office? ____________________
Have you ever seen a chiropractor before? ________ If yes, who and when? ____________________
Employer: ____________________ Employer Address: ____________________
Occupation: ____________________ Office Phone: ____________________
Spouse Name: ____________________ Date of birth: ____________________
Names and Ages of Children: ________________________________
Name of Nearest Relative: ____________________ Phone Number: ____________________

Family Medical Doctor: ____________________ Clinic Name: ____________________ Phone: ____________________
When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your care at this office?
Yes ○ No○ (circle one)

HISTORY OF PRESENT ILLNESS:

Chief Complaint or Purpose of this appointment: ________________________________
Date symptoms appeared or accident happened: ________________________________
Is this due to: ○ Auto ○ Work ○ Other ________________________________
Have you ever had the same or a similar condition? ○ Yes ○ No If yes, when and describe: ____________________
____
Days lost from work: ________________________________

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

○ Broken or Fractured Bones	○ Osteoarthritis	○ Eating Disorder	○ Dizziness	○ Stroke
○ Circulatory Problems	○ Epilepsy	○ Alcoholism	○ Backaches	○ Arthritis
○ Hypertension	○ Pace Maker	○ Drug Addiction	○ Heart Trouble	○ Neuritis
○ Rheumatoid Arthritis	○ Strokes	○ HIV Positive	○ Diabetes	○ Anemia
○ A Congenital Disease	○ Seizures/Convulsions	○ Gall Bladder	○ Sinus Trouble	○ Hernia
○ Excessive Bleeding	○ Ruptures	○ Depression	○ Headaches	○ Cancer
○ High/Low Blood Pressure	○ Coughing Blood	○ Ulcers	○ Nervousness	○ Thyroid
○ Numbness	○ Asthma	○ Rheumatic Fever	○ Digestive Disorders	○ Osteoporosis

Have you had any major illnesses, injuries, falls, or auto accidents? ________________________________

Have you had any surgeries? Please list in chronological order. ________________________________
Women, please include information about childbirth. ________________________________

Has a physician treated you for any health condition in the last year? ○ Yes ○ No If yes, describe: ____________________
Date of last physical examination: ____________________

What medications or drugs are you currently taking? ________________________________
____
Do you have any allergies to any medications? ○ Yes ○ No If yes, describe: ____________________

Please list any other health problems you have, no matter how insignificant they may be: ____________________
____

Print Name ____

PATIENT INFORMATION

CASE HISTORY

SOCIAL HISTORY:

Do you drink alcoholic beverages? ___________ If so, how much per week? ____

Do you use any tobacco products? ___________ Do you smoke? _________________ If so, packs per day: _______________________

Do you take vitamin supplements? ___________ If so, please list: ____

Do you consume caffeine? __________________ If so, how much per day: ____

Do you exercise? _______ If yes, what is the frequency and type of exercise? ____

Do you drink water? ○ Yes ○ No How many glasses a day? _______

What are your hobbies?_____ ____

What percentage of time during the day (at home or at your job away from home) do you spend:

Lifting _____% Sitting _____% Bending _____% Working at a computer_____%

FAMILY HISTORY:

Father: ○ living ○ deceased (check one) Cause of death and age at death if deceased: _____________________________________

Mother: ○ living ○ deceased (check one) Cause of death and age at death if deceased:

____

Check if applicable to you: ○ As an adopted child, little is known of my birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list: ________________________________

____

FAMILY DISEASES (if applicable, indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis ____ Cancer ____ Mental Illness ____

Diabetes ____ Asthma ____ Heart Disease ____

Stroke ____ Kidney Disease ____ Lung Disease ____

Arthritis ____ Liver Disease ____ Other_____________________

Please check any and all insurance coverage that may be applicable in this case:

○ Major Medical Insurance ○ Worker's Compensation Insurance ○ Medicaid ○ Medicare ○ Medicare Supplement Plan

○ Auto Accident Insurance ○ Medical Savings Account & Flex Plans

○ Other____

Name of Primary Insurance Company: ____

Name of Secondary Insurance Company (if any): ____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature ____ Date_________________________________

Guardian's Signature Authorizing Care ______________________________________ Date_________________________________

Print Name ______________________________________

PATIENT INFORMATION

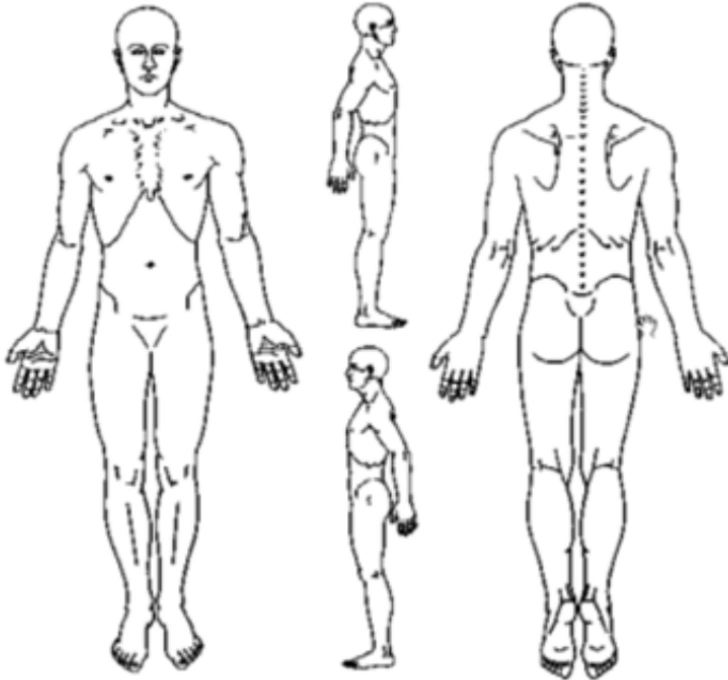
CASE HISTORY

SUMMARY:

Rate the severity of your pain, on a scale of 0-10, with 10 being extreme pain:

No Pain o0 o1 o2 o3 o4 o5 o6 o7 o8 o9 o10 Extreme Pain

PLEASE MARK YOUR AREA OF CONCERN ON THE DIAGRAM BELOW *(AFTER PRINTING)*



1. What is your major symptom?

____

2. What does this prevent you from doing or enjoying?

____

3. When was the first time you noticed this problem?

____

How did it happen?

____

Has it become worse recently? o Yes o No If yes, when and how?____

Have you experienced this before? o Yes o No If yes, when?

____

4. How frequent is the condition? o Constant o Intermittent

o Daily o Night Only o Other________________

How long does it last? o All Day o Few Hours o Other ________________________________

Has it been: o Improving o Worsening o Staying the Same

5. Do you have arm pain? o Yes o No

6. Do you have arm numbness or tingling? o Yes o No

7. Do you have leg pain? o Yes o No

8. Do you have leg numbness or tingling? o Yes o No

9. Do you have any weakness in your arms or legs? o Yes o No

10. Describe the pain: (check all that apply) ☐Sharp ☐Dull ☐Numbness ☐Tingling ☐Aching ☐Burning ☐Stabbing o Other If other, describe: ____

11. Have you tried anything to relieve the pain? o Yes o No If yes, describe: __________________________

Did this help? ____

____

12. What makes the problem worse? ☐Standing ☐Sitting ☐Lying ☐Bending ☐Lifting ☐Twisting ☐Turning head ☐ Other If other, describe: ____

13. Do you have difficulty sleeping? o Yes o No Do you sleep on your: ☐Stomach ☐Side ☐Back

14. Are there any other conditions or symptoms that may be related to your major symptom?

o Yes o No If yes, describe:____

Are there other unrelated health problems? o Yes o No If yes, describe______________________________

____

WOMEN ONLY: 15. Are you pregnant or is there any possibility you may be pregnant? o Yes o No o Uncertain

Patient's Signature ________________________________ Date________________________

Doctor's Initials______________________

Print Name ________________________________

PATIENT INFORMATION

INFORMED CONSENT FOR CHIROPRACTIC CARE
PATIENT HEALTH INFORMATION CONSENT FORM

In coming to the Chiropractic Physician, a patient gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if a physician at Health Care Center accepts me as a patient, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Name ________________________________ Date____________

Patient Signature________________________________ Date____________

(if patient is a minor child)
Parent - Legal Guardian (circle one) Name ________________________ Date____________

Parent - Legal Guardian Signature________________________ Date____________

Print Name ______________________________________

PATIENT INFORMATION

FINANCIAL POLICIES

Welcome to our office! We're happy you have chosen Chiropractic for your health care needs. Your health is your greatest asset and therefore one of the best things you can invest in financially.

YOUR FIRST VISIT
All services rendered during the first visit must be paid for at that time. Patients without insurance coverage may pay by cash, check, electronic debit or credit card. Patients with insurance can pay for their deductible and/or co pay by cash, check, electronic debit or credit card provided their coverage has been verified. Patients with insurance that has not been verified are on a cash basis until coverage is confirmed. If this results in an overpayment, we will credit your account or reimburse you when our office receives final payment from the carrier and care has been completed.

MANAGED CARE POLICIES
Patients with managed care policies that the doctor is a contracted provider for are responsible for co-payments and noncovered services. Payment for noncovered services and co-payments will be collected prior to seeing the doctor and can be paid for by cash, check, electronic debit or credit card. Patients seeing the doctor more that one visit per week are encouraged to make payment for all co pays and noncovered services at the beginning of each week. Patients with managed care contracts that the doctor is not a contracted provider for may have out of network coverage. This coverage is usually subject to a deductible and percentage co pay. See deductible policies below.

DEDUCTIBLE POLICIES
We gladly accept insurance assignment if the insurance company: 1.Verifies the deductible has been met, 2. Provides details of the available coverage, 3. Agrees to make payment directly to our office. It must be understood; insurance is an agreement between the patient and the insurance company. The agreement is not between the insurance company and this office. In every case, the patient or their Guardian is ultimately responsible for all fees. Our office will file the necessary primary claim forms at no charge. Assistance with additional forms and policies may be subject to a small clerical fee. Some insurance companies require special forms and will not accept universal claim forms. In these cases, the patient is responsible for supplying the required forms with the patient's portion completed and signed.

PERSONAL INJURY/AUTOMOBILE ACCIDENT
Chiropractic services are usually covered very well in these cases. We require that the insurance company verify coverage and that the accident was reported. We also need copies of any accident forms or police reports within the first week of care. If you have Personal Injury Protection (PIP) on your auto insurance or on the policy of the car in which you were riding, it is our policy to file on PIP first, before any third party insurers. If an attorney is handling your case, we will accept a Letter of Protection (LOP) at our discretion. Although the patient is ultimately responsible for the bill, we will take assignment as long as the patient is under active care. If the patient suspends or terminates care, all fees for services are due immediately.

"ON THE JOB INJURY"/WORKERS COMPENSATION
Workers compensation pays in full for Chiropractic care. Written verification that the accident was reported to the employer is required prior to the patient's initial visit with the doctor.

MEDICARE
We do accept assignment from Medicare. The check is sent directly to our office in payment for the services that Medicare will cover. For Chiropractors, this includes only manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met and the patient will be required to pay the remaining 20%. In some instances, Medicare supplement policies will cover Medicare's non-covered services. If the patient does not have secondary insurance coverage and/or a Medicare supplement policy, those qualified may be eligible for Financial Hardship. Please inquire about Financial Hardship at the front desk. Our office completes all required Medicare forms at no charge.

CASH PAYMENT
Patients without insurance coverage may pay for care by cash, check, electronic debit or credit card. Payment is due at the time services are rendered. Checks and Electronic debiting are subject to a fee of $25 for each returned check.

AFTER HOURS/EMERGENCIES
Emergency care after hours or on weekends and holidays is available. Please be aware that after hours calls are subject to additional charges, which are not covered by insurance carriers. These charges are in addition to the service rendered and the patient is solely responsible for their payment.

PAST DUE ACCOUNTS
Patient balances will be collected primarily through Credit Card Guarantees and/or Authorization for Electronic Debit. If necessary, statements will be issued to patients with outstanding account balances. Delinquent accounts are reported to an attorney for collection.

ASSIGNMENT OF BENEFITS
Assignment of benefits simply means that the patient gives their permission to the insurance carrier to make payments directly to our office. Cash patients are not subject to assignment of benefit agreements. The patient who does not wish to assign benefits to our office will be treated as a cash patient. Under specific circumstances patients may be asked to reassign benefits once every 90 days. All insurance patients must complete a new assignment of benefits during the first visit of each calendar year.

RELEASE OF INFORMATION
All patients who assign benefits to our office must sign a release of information form. This form gives our office permission to release information about the patient's health that may be required by the insurance carrier in order to provide benefits. Patients who do not wish to have their health information released and does not sign an information release, cannot assign benefits. This mean the patient will not be able to use their insurance and payment will be on a cash basis. Cash patients do not have to sign an information release. Please note that the information release for our office is written to cover a variety of insurance cases. If there is anyone a patient does not want information released to, our office should be informed immediately.

I have read, understood and agree to abide by the terms of this office's Financial Policy, and have received a copy of it. Any portion of this agreement that is found to be void or invalid will have no effect on other portions of this agreement.

Patient's Signature ______________________________________ Date ____________________________

Guardian's Signature Authorizing Care______________________________ Date ____________________________