

PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name _____
Address _____
City _____ State _____
Zip _____ Home phone _____
Birth date _____ Cell Phone _____
Age _____ Gender _____ Number of children _____
Employer _____
Work address _____
Work phone _____
Type of work _____
Status Single Married Divorced Widowed Partner
Social Security # _____
E-mail address _____
Payment method Cash Check Credit card Insurance

REASON FOR THIS VISIT

Describe the purpose of this visit _____

Is the purpose of this appointment related to:
 Job Sports Auto Fall
 Home Injury Chronic Discomfort Other
If job related, have you made a report of your accident to your employer? Yes No
Where specifically is the problem located? _____
When did this condition begin? _____
Has this condition
 gotten worse stayed constant comes and goes
Does this condition interfere with
 Work Sleep Daily routine Other activities
Please explain _____
Has this condition occurred before? Yes No
Please explain _____
Have you seen other doctors for this condition? Yes No
Doctor's Name(s) _____
Type of treatment _____
Results _____

ABOUT YOUR PARTNER

Name _____
Employer _____
Work phone _____
Type of work _____

HEALTH HABITS

	No	Yes
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink coffee, tea or soda?	<input type="checkbox"/>	<input type="checkbox"/>
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear:		
<input type="checkbox"/> Heel lifts <input type="checkbox"/> Sole lifts <input type="checkbox"/> Inner soles <input type="checkbox"/> Arch supports		

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____
Have you heard about us in/on: Paper Clinic Sign Yellow Pages
Have you been adjusted by a Chiropractor before? Yes No
Reason for those visits? _____
Doctor's name _____
Approximate date of last visit _____
Has any adult in your family seen a Chiropractor? Yes No
Has any child in your family seen a Chiropractor? Yes No

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that

- Doctors of Chiropractic work with the nervous system? Yes No
- The nervous system controls all bodily functions and systems? Yes No
- Chiropractic is the largest natural healing profession in the world? Yes No
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Yes No

GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. 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** – Symptomatic relief of pain or discomfort
- Corrective care** – Correcting and relieving the cause of the problem as well as the symptoms
- Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care
- I want the Doctor to select the type of care appropriate for my condition.

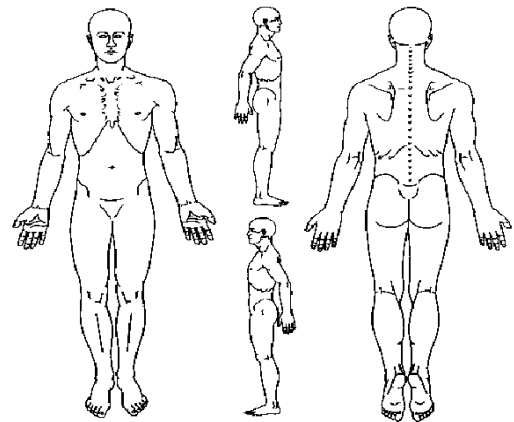
Patient's signature

Date

MEDICATIONS I NOW TAKE

- Cholestral medication
- Stimulants Blood thinners
- Tranquilizers Pain killers (including aspirin)
- Muscle relaxers _____
- Insulin _____

Vitamins & Supplements I now take: _____



N=NUMBNESS P=PAIN T=TINGLING ST=STIFFNESS
A = ACHE D= DULL SH= SHARP/SHOOTING B=BURNING
Please mark the diagram above accordingly

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Severe or frequent headaches | <input type="checkbox"/> Heart surgery/
Pacemaker | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Heart attack/stroke | <input type="checkbox"/> Diabetes | For women: |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Shingles | Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Kidney problems | Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Hepatitis | Are you taking birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Frequent neck pain | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Cancer | Do you experience painful periods? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Numbness in Arms/legs/hands | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chemotherapy | Do you have irregular cycles? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Pain in Arms/legs/hands | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic fever | Do you have breast implants? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Lower back problems | <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Psychiatric problems | |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Thyroid problems | |
| | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Surgeries | |
| | <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> _____ | |
| | | <input type="checkbox"/> _____ | |

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill of service. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I further agree to pay all collection fees and interest should I not make required payments.

Signature: _____ Date: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT
PATIENT RECORD OF DISCLOSURES

Acknowledgement Form

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Home Telephone: _____ | <input type="checkbox"/> Written Communication: _____ |
| <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> O.K. to mail to my home address |
| <input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> O.K. to mail to my work/office address |
| <input type="checkbox"/> Work Telephone _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> O.K. to leave message with detailed information | _____ |
| <input type="checkbox"/> Leave message with call-back number only | _____ |

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Signature

Date

Print Name

Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below if completed properly, will constitute an adequate health record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Back to Health Family Chiropractic

Payment for Services and Supplies Rendered

This is the fun part about our **Financial Policy**. We work hard to keep the cost of chiropractic care down and affordable. You, our wonderful patients, can help us accomplish this by paying your co-pay and any outstanding balances owed at the time of service. The following is a summary of our payment policy.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Yes, this is true. We require payment at the time we provide services unless other arrangements have been made in advance. This includes applicable deductibles, co-insurances (your percentage of the balance due) and co-pays for participating insurance companies. We accept cash, local checks, debit cards and credit cards; Visa, Mastercard and Discover. There is a \$25.00 service charge for returned checks, and we reserve the right to charge a \$5.00 processing/administrative statement fee for non-payment of co-pays at the time of service.

We do understand extenuating circumstances may occasionally cause **financial hardship**. Please call or speak personally with our Billing Specialist to discuss a reasonable payment agreement.

INSURANCE COVERAGE

At the time of your visit, you will be asked to provide your medical insurance card for correct claim processing. As a courtesy to our patients, we process claims for any insurance group in which we are considered participating providers. (This means we have reached a contractual agreement with them for payment of services Back to Health Chiropractic provides to their members.) You are expected to pay your deductible and co-payments or co-insurance **at the time of service** **whether we are a participating provider or not**. If we have not received payment from your insurance company within 45 days, (2 billing cycles), you will be expected to pay the balance in full. You are ultimately responsible for all charges incurred. If your insurance company denies payment for any reason other than an error on our part, it is **your** responsibility to follow up with them to appeal. We will not research denials for you unless it is caused by an error within our office. We will be happy to resubmit charges, once you have researched a solution with a representative from your insurance company.

We will gladly bill secondary insurances if we are on their list of participating providers and you notify us that you have a secondary insurance at the time of service.

If we do not participate with your company, or you cannot provide proof of medical insurance coverage, it is expected you will make payment at the time of service.

REFERRALS

If Dr. Molly determines you need to be seen by a specialist, it is your responsibility to check with your insurance carrier to determine if a Referral or Prior Authorization is required. There are numerous levels of coverage and policy requirements within each carrier/company. Our staff is not responsible for knowing whether or not your policy has these requirements, however; they will help you and your provider process the referral.

MISSED OR "NO SHOW" APPOINTMENTS OR LATE CANCELLATIONS

When you miss a scheduled appointment, or cancel it close to the appointed time, it represents a cost to you, to us and to the other patients. Please try to give a 24 hour notice if you can not make an appointment. We reserve the right to charge a **\$25.00 fee** for missed or late cancelled appointments. Excessive missed or "no-show" appointments will sadly result in discharge from the Back to Health practice.

CUSTODIAL PARENTS

By law, you are responsible for payment of your child's medical bills, even if you are not the subscriber of the insurance policy that covers your child's medical services.

SIGNATURE

I have read and understand Back to Health Family Chiropractic's Financial Policy. I agree I am responsible for the balance of my account for any professional chiropractic services rendered. I certify the patient information given is true and accurate to the best of my knowledge. I also agree that if it becomes necessary to forward my account to a collection agency, I will be responsible for any fees incurred by the collection agency, in addition to any amount owed for services.

Signature of insured / responsible representative

Date

Witness

Date

AUTOMOBILE ACCIDENT HISTORY

AUTOMOBILE ACCIDENT:

Name _____ Sex M / F Age: _____

Address _____ Driver's License # _____

GENERAL SYMPTOMS:

Did you hit any part of your body during the collision, for example, head on the dash, chest on steering wheel? Y / N

If Yes, which part and how? _____

Where you taken after the accident? _____

Were you hospitalized? Y / N When did you go? _____ If yes, how did you get there? _____

If by ambulance, did the ambulance attendants place you in a ___ neck brace ___ back brace ___ other _____

Any medications or medical supplies given? _____

Did you have x-rays, CT, MRI taken? Y / N When? _____ Where? _____

How long were you there? _____

Did you receive care from any other health care specialist? Y / N ? If yes , who? _____

What type of care were you given and for how long? _____

Immediately after the accident were you ___conscious ___dazed/confused ___unconscious
If unconscious for how long? _____

Where did you feel the pain initially? _____ 72 hours later? _____

What are your current symptoms? _____

Have you ever been injured in a similar manner? Y / N If yes, how and when? _____

ACCIDENT HISTORY:

Date and Time: _____

State How Accident Happened in your own words _____

Were you driving? Y / N Passenger? Y / N Pediatrician? Y / N

Was it your car? Y / N If not who's car was it? _____

Passenger? Y / N Were you in the Front? Back? right middle or left side? _____

At the time of impact were you: ___looking straight ahead ___ looking to the right ___ looking to the left
___ looking down ___ looking up

AUTOMOBILE ACCIDENT HISTORY(cont.)

Was your vehicle shoved: ___ forward ___ backward ___sideways

Did your vehicle hit: ___another car ___ a sign ___ guard rails ___ bridge ___other _____

Were you shoved: ___ forward ___backward ___sideways

Did your seat have a head restraint(headrest?) Y / N If yes, what position: ___low ___midposition ___high

Did your head ride over the headrest? Y / N Did your hat/glasses end up in the back seat or rear window? Y / N

Did any other part of your body hit the interior of the vehicle? Y/ N if yes please specify: ___ seatbelt restraints
___ steering wheel ___ dashboard ___ windshield ___side door ___ side window ___ other _____

Were you holding the steering wheel? Y / N Did you brace your arms Y/ N ___steering wheel ___ dash

Were you surprised by the impact? Y / N

Did you brace your legs against the floorboard? Y /N Was your ankle turned? Y / N

Did the vehicle go into a spin or roll as a result of the impact? Y / N

How much damage to the outside of your vehicle? ___ none ___ some ___ a lot ___ totaled

How much damage to the other vehicle? ___ none ___ some ___ a lot ___ totaled

Other people in car: Name and Address: _____

Other vehicle ? ___ car ___ truck ___ motorcycle ___ other _____

Who was ticketed? _____ why? _____

Seat Belt On? Y / N Shoulder harness on? Y / N Did the seat belt break? Y/ N Did it contribute to your pain? Y/N

Was it daylight, night, dusk or dawn? _____

Were you tired? Y / N Were you awake? Y / N How long had you been in the car? _____

Where were you prior to the accident? _____ What was the weather conditions? _____

_____ Traffic conditions? _____

What was the posted speed limit? _____ How fast were you going? _____ The other car? _____

Was your vehicle in: ___ park ___ neutral ___ in gear ___ moving ___ stopped

Were your brakes being applied? Y / N

Type of Road: Two Lane _____ Four Lane _____ Gravel _____ Tar _____ One Way _____ Divided _____

Did it happen at: ___ a stop sign? ___ traffic light? ___ at an intersection? ___ other? _____

Was your car hit? ___Front ___ Back ___Left side front ___Left side Back ___Right side front ___Right side back

What damage was done to your car? Inside _____

Outside _____

Other _____

AUTOMOBILE ACCIDENT HISTORY(cont.)

If you struck another car, did you strike it: ___Front ___ Back ___Side

What was the damage to the other car? Inside _____

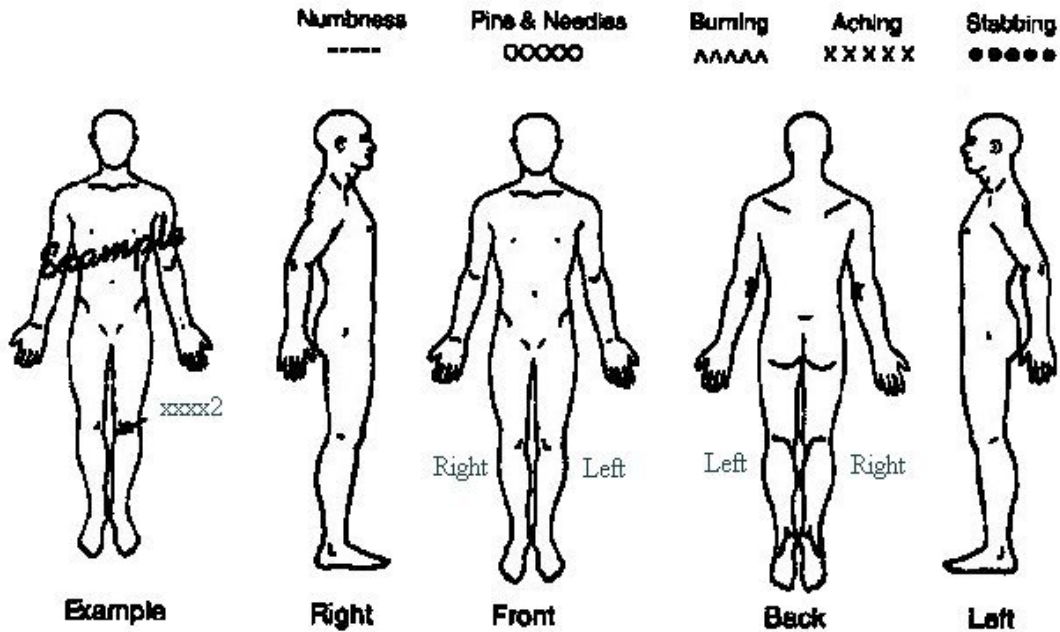
Outside _____

Have you lost time from work? Y / N If yes how long? _____ Does it bother you to ride in a car now? Y/N

ATTORNEY INFORMATION

Do you have an attorney: Y / N If yes: Name, address and phone number: _____

Please fill out the diagram as you feel currently



Patient Signature: _____

Date: _____

Print Name : _____

Witness: _____

Date: _____