

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
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Do you smoke? No Yes

Do you drink alcohol? No Yes

Do you drink coffee, tea or soda? No Yes

Do you exercise regularly? No Yes

Do you wear:

Heel lifts Sole lifts Inner soles 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.

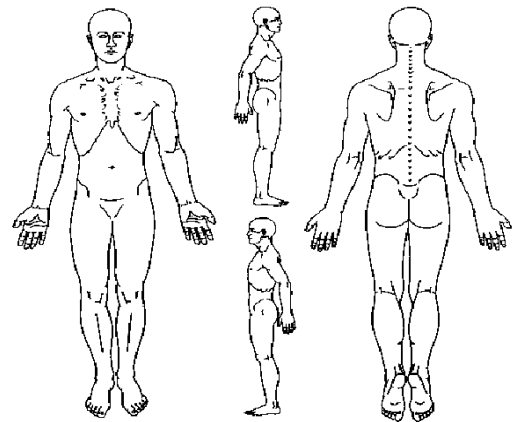
Patient's signature

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

WORKER'S COMPENSATION HISTORY

PATIENT _____ MALE / FEMALE DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ AGE _____ D.O.B. _____

NAME OF COMPENSATION CARRIER _____

PHONE _____ SUPERVISOR'S NAME _____

ADDRESS OF COMPENSATION CARRIER _____

_____ CLAIM # _____

EMPLOYERS NAME _____ PHONE _____

ADDRESS _____

OCCUPATION _____

DATE OF INJURY _____ TIME _____ A.M. / P.M.

WHAT IS YOUR HEALTH CONCERN? _____

ARE YOU OFF WORK? YES NO LAST DATE WORKED? _____

HAVE YOU RETURNED TO WORK SINCE THE ACCIDENT? YES NO DATE _____

ANY PREVIOUS WORKERS COMPENSATION INJURIES? YES NO DATE _____

LENGTH OF TIME WORKED PREVIOUS TO INJURY _____

EXPLAIN DETAILS OF THE ACCIDENT _____

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS CONDITION? YES NO

IF YES, LIST DR.'S NAMES AND NUMBERS _____

PRIOR TO THE ACCIDENT, HAVE YOU EVER HAD COMPLAINTS SIMILAR TO THE ONES YOU ARE EXPERIENCING NOW? YES NO

DESCRIBE _____

PATIENT'S SIGNATURE _____ DATE _____