

# 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

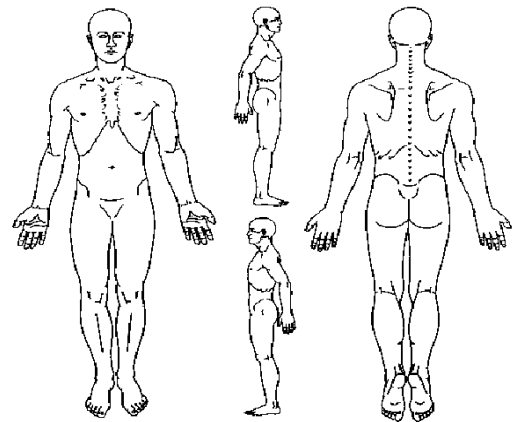
- Cholestral medication
- Stimulants                       Blood thinners
- Tranquilizers                     Pain killers (including aspirin)
- Muscle relaxers                 \_\_\_\_\_
- Insulin                               \_\_\_\_\_

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/<br>Pacemaker | <input type="checkbox"/> Arthritis            |   |
| <input type="checkbox"/> Sinus problems               | <input type="checkbox"/> Heart attack/stroke         | <input type="checkbox"/> Diabetes             | <b>For women:</b>   |
| <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"/> <b>Home Telephone:</b> _____                    | <input type="checkbox"/> <b>Written Communication:</b> _____    |
| <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"/> <b>Work Telephone</b> _____                     | <input type="checkbox"/> <b>Other:</b> _____                    |
| <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 \_\_\_\_\_

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

DESCRIBE \_\_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_