# Patient Health Information Consent Form

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.
8. From time to time we may send you birthday cards or letters, use your name on a birthday list or use your name on a referral board in our office. By your signature below you have given us permission to do so.

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

Name of Patient Signature of Patient Date

# Insurance Questionnaire

***The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.***

1. Type of insurance: Medicare____Medicaid____Champus___CampVA____
   Group Health Plan____ Other____Insured's ID Number_____
2. Patient Name:_____
3. Insured's Name (as it appears on the insurance card):_____
4. Patient's Address:_____
   City_____State_____ Zip_____Tel #_____
5. Insured's Address (if same as patient put "same"):_____
   City_____State_____ Zip_____Tel #_____
6. Patient Status (circle one): Single Married Other Employed Full-time Student Part-time Student
7. Other Insured's Name (if applicable):_____
   Other Insured's Policy or Group Number:_____
   Other Insured's Date of Birth:_____ Male_____Female_____
   Employer's Name or School Name:_____
   Insurance Plan Name or Program Name:_____
8. Is the condition we are treating related to current or previous employment? Yes____ No____
9. Is the condition we are treating related to an auto accident? Yes____ No____
10. Is the condition we are treating related to another type of accident? Yes ____ No____
11. Insured's Policy Group or FECA Number:_____
    Insured's Date of Birth:_____Male_____Female_____
    Employer Name or School Name:_____
    Insurance Plan Name or Program Name:_____
12. Is there another health benefit plan? Yes____ No____

**Patient's or Authorized Person's Signature:** I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: _____Date:_____

**Insured's or Authorized Person's Signature:** I authorize payment of medical benefits to for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: _____Date:_____

**MEDICARE ONLY**

*All doctors have been instructed to ask the following questions of all Medicare patients.*

1. Do you or your spouse work for a company that provides you with health insurance? Yes___ No___
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes___ No___
3. Is the illness or injury the result of an accident or illness that occurred at work? Yes___ No___
4. Is this illness or injury the result of an accident or other injury? Yes___No___
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes__ No__
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes___ No___
7. Do you have a Medicare Medigap Policy? Yes___ No___Name of Company_____
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? Yes___ No___

# CHIROPRACTIC REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

## 2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

## 3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

**IN CASE OF EMERGENCY, CONTACT**

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

## 4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

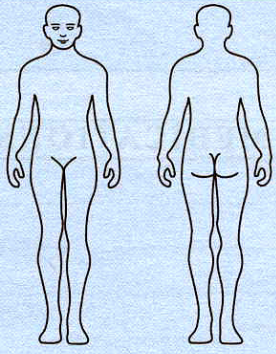
## 5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

## 6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV ☐ Yes ☐ No | Chicken Pox ☐ Yes ☐ No | Liver Disease ☐ Yes ☐ No | Rheumatoid Arthritis ☐ Yes ☐ No |
| Alcoholism ☐ Yes ☐ No | Diabetes ☐ Yes ☐ No | Measles ☐ Yes ☐ No | Rheumatic Fever ☐ Yes ☐ No |
| Allergy Shots ☐ Yes ☐ No | Emphysema ☐ Yes ☐ No | Migraine Headaches ☐ Yes ☐ No | Scarlet Fever ☐ Yes ☐ No |
| Anemia ☐ Yes ☐ No | Epilepsy ☐ Yes ☐ No | Miscarriage ☐ Yes ☐ No | Stroke ☐ Yes ☐ No |
| Anorexia ☐ Yes ☐ No | Fractures ☐ Yes ☐ No | Mononucleosis ☐ Yes ☐ No | Suicide Attempt ☐ Yes ☐ No |
| Appendicitis ☐ Yes ☐ No | Glaucoma ☐ Yes ☐ No | Multiple Sclerosis ☐ Yes ☐ No | Thyroid Problems ☐ Yes ☐ No |
| Arthritis ☐ Yes ☐ No | Goiter ☐ Yes ☐ No | Mumps ☐ Yes ☐ No | Tonsillitis ☐ Yes ☐ No |
| Asthma ☐ Yes ☐ No | Gonorrhea ☐ Yes ☐ No | Osteoporosis ☐ Yes ☐ No | Tuberculosis ☐ Yes ☐ No |
| Bleeding Disorders ☐ Yes ☐ No | Gout ☐ Yes ☐ No | Pacemaker ☐ Yes ☐ No | Tumors, Growths ☐ Yes ☐ No |
| Breast Lump ☐ Yes ☐ No | Heart Disease ☐ Yes ☐ No | Parkinson's Disease ☐ Yes ☐ No | Typhoid Fever ☐ Yes ☐ No |
| Bronchitis ☐ Yes ☐ No | Hepatitis ☐ Yes ☐ No | Pinched Nerve ☐ Yes ☐ No | Ulcers ☐ Yes ☐ No |
| Bulimia ☐ Yes ☐ No | Hernia ☐ Yes ☐ No | Pneumonia ☐ Yes ☐ No | Vaginal Infections ☐ Yes ☐ No |
| Cancer ☐ Yes ☐ No | Herniated Disk ☐ Yes ☐ No | Polio ☐ Yes ☐ No | Venereal Disease ☐ Yes ☐ No |
| Cataracts ☐ Yes ☐ No | Herpes ☐ Yes ☐ No | Prostate Problem ☐ Yes ☐ No | Whooping Cough ☐ Yes ☐ No |
| Chemical Dependency ☐ Yes ☐ No | High Cholesterol ☐ Yes ☐ No | Prosthesis ☐ Yes ☐ No | Other _____ |
| | Kidney Disease ☐ Yes ☐ No | Psychiatric Care ☐ Yes ☐ No | _____ |

### EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

### WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

### HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

| Injuries/Surgeries you have had | Description | Date |
|---|---|---|
| Falls | | |
| Head Injuries | | |
| Broken Bones | | |
| Dislocations | | |
| Surgeries | | |

## 7 MEDICATIONS

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

## ALLERGIES

## VITAMINS/HERBS/MINERALS

**Patient Name:**_____ **Patient #:** _____

## PAYMENT POLICY INFORMATION

Payment for Services will be by: Cash___ Check____ Credit Card_____

**Chiropractic Services provided in this office are payable the day services are rendered unless other arrangements have been made prior to seeing the doctor.**

1. Patients are personally responsible for all charges. If the staff is unable to verify insurance benefits prior to the end of your first visit, payment is due in full.

2. There will be a $5.00 charge for paperwork above and beyond the normal claims information needed to process group or individual insurances or if more than 2(two) insurances are involved.

3. Payment Plan is available upon approval of credit extension by the Office Manager. I authorize a credit check if credit is extended.

4. Assignment of Insurance benefits will be accepted upon proper verification of coverage and at the discretion of this office. There will be verification of coverage, however **"benefits quoted are not a guarantee of payment".** Benefits are determined at the time of processing.

5. Any balance remaining after 60 days with no action on the account will be charged an 18% per annual service charge.

6. A collection fee equal to 40% of balance will be added to all delinquent accounts over 90 days past due that have to be sent to a collection agency.

7. I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself - not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports at no charge to assist in collecting from my insurance company.

8. If mine is a regular insurance case, I agree to pay a percentage of services as they are rendered. 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.

**I HAVE READ AND UNDERSTAND THE ABOVE POLICY:**

**PATIENT'S SIGNATURE: X**_____ **Date:**_____
**(OR GUARDIAN / GUARANTOR )**

**Witness's Signature:**_____ **Date:**_____