Confidential Patient Health Record Date:_____

PERSONAL HISTORY

Full Name:_____ Home Address:_____

City:_____State_____Zip:_____ E-mail Address:_____

Home Phone: (____)_____ Birth Date:_____Age:_____Sex: ☐ M ☐ F

Social Security # _____ Driver's License Number:_____

Business Employer:_____Business Phone(____)_____Type of Work:_____

Circle One: **Married Single Widowed Divorced Separated** Name of Spouse:_____

Spouse's Employer:_____Type of Work_____

Names and Ages of Children:_____

Referred To This Office By:_____

Emergency Contact: Name:_____Phone # (____)_____Relationship:_____

INSURANCE INFORMATION

Who is Responsible For Your Bill, You and ☐Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid

Personal Health Insurance (Name)_____ Health Ins. ID #_____

Group#_____Primary Insured's Name_____Birth Date:_____

CURRENT HEALTH CONDITION

Purpose of this appointment_____

Other Doctors Seen For This Condition: ☐Yes ☐ No Who?_____

Type of Treatment:_____ Results:_____

When Did This Condition Begin?_____ Has This Condition Occurred Before? ☐ Yes ☐ No

Is Condition: ☐Job Related ☐ Auto Accident ☐Home Injury ☐Fall ☐Other:_____

Date of Accident:_____ Time of Accident:_____

Have You Made A Report of Your Accident To Your Employer ☐Yes ☐No

Drugs You Now Take: ☐ **Nerve Pills** ☐ **Pain Killers/Muscle Relaxers** ☐ **Blood Pressure Medicine** ☐ **Insulin**

Others:_____

Do You Wear A Shoe Lift? ☐ Yes ☐ No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?_____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ☐ Appendectomy ☐Tonsillectomy ☐Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other:_____

Major Accident or Falls:_____

Hospitalization (Other Than Above):_____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit_____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE

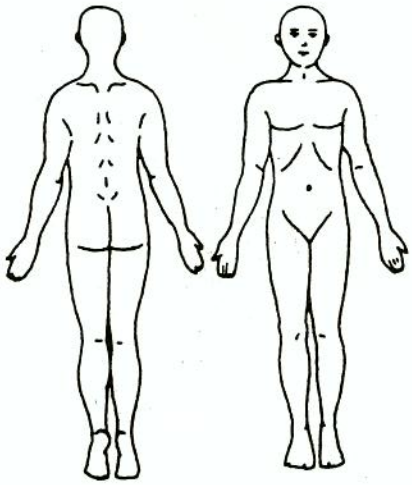
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FEMALES ONLY:

When was your last period?_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort.

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

_____

Doctor's Signature

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). 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

☐ Corrective Care

☐ Check here if you want the Doctor to select the type of care appropriate for your condition.

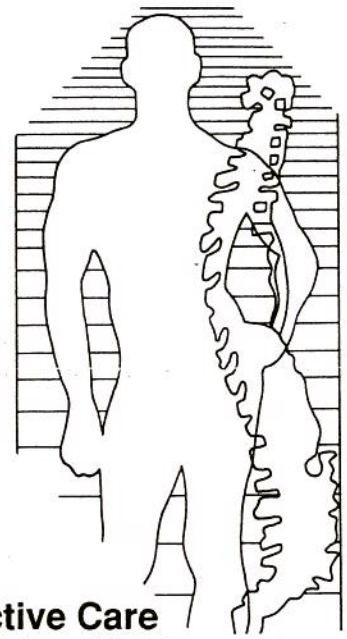
Date

Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!

Relief Care

Relief care is that necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in its length or time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature **X** _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

Documentation of Health Information

You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment, or health care operations. Our documentation procedures will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes.

You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing, any concerns you may have regarding the privacy of your health information.

Patient Acknowledgment

Patient Name(s):

_____

_____

_____

Thank you very much for taking time to review how we are carefully using your heath information. If you have questions, please let us know. If not ,we would appreciate your acknowledging by signature that you have received, thoroughly reviewed and understand this policy.

_____ *Date*___/___/___

Patient Signature

Thank You For Your Trust and Confidence

HIPAA HAPPENINGS

This notice describes how your health information may be used and h you can gain access to this information. Please review it carefully.

Our Promise To You our Valued Patient....

This is not meant to alarm you. Quite the opposite. We want to assure you that take the new Federal HIPPA (Health Insurance Portability and Accountability A laws seriously. These laws were written to protect the confidentiality of your hea information. We trust you will never delay treatment in our offices because of f that your personal health information might be unnecessarily disclosed to oth outside our office.

Why A Privacy Policy Now?

The most significant variable that has motivated the Federal government to lega enforce the privacy of health information is the rapid evolution of the use electronic technology in the administration of health care business. T government has appropriately sought to standardize and protect the electror exchange of your health information. This has challenged us to review not on how your information is used within our computers but also with the Intern phones, fax machines and any device used to copy or transfer that data.

We want to advise you that we have developed policies and procedures for o practice to assure that your personal or health information will be shared only required and only for the purpose of administering your case. Our office is subje to State and Federal laws regarding the confidentiality of your health informatio We will assure our adherence to those laws and we want you to understand o procedures and your rights as a valued patient.

Your health information will be communicated only for the purpose of conducti health care business and obtaining payment for services. Be assured that witho your written permission, your health information will not be used for any oth purpose.

How Your Health Information May Be Used To Provide Treatment

Within our office, your health information will be used to provide you the best ca and services possible. This may include administrative and clinical procedur designed to optimize scheduling and coordination between you and all offi personnel. In addition, we may share this information with referring physician clinical pathology laboratories or other health professionals providing yc treatment.

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIENS AND AUTHORIZATION
("Agreement")

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and or other legal entities ("payers") which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, illnesses past or future ("condition") to pay directly to and exclusively in the name of Chiro+Plus Chiropractic Clinics ("ChiroPlus" or "office") such sums as may be owing to Chiro+Plus for charges incurred by me, including but not limited to charges for treatment , narrative reports, depositions, testimony, and any other charges incurred by me at the office ("charges"). I further grant a contractual lien to Chiro+Plus with respect to any charges, applicable to all payers; however, I understand that nothing in this Agreement shall be construed as an election by Chiro+Plus to claim protection under any statuary lien law. For the purpose of this Agreement "benefits" shall include, but shall not be limited to proceeds from any settlement, judgment, or verdict as well as any proceeds relating to commercial health or group insurance, disability benefits, workers compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements and any other benefit or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that in the event a payer refuses to pay Chiro+Plus, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Chiro+Plus to the extent of my charges, as well as any and all causes of action that I might have against such payer to prosecute such causes of action either in my name or in the offices name, and to settle or otherwise resolve such causes of action as the office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a Letter of Protection to this office regarding my charges. Upon issuance I hereby agree that such letter(s) of protection cannot be revoked or modified without expressed written consent of this office. I further direct each attorney to provide immediate notice to the office regarding any funds received by the attorney relating to my accident, to promptly pay such office, and to provide a full accounting of such funds to the office upon its request.

I hereby direct all payers to release to Chiro+Plus any information regarding my coverage or benefits which I may have including, but not limited to, the amount paid thus far, and the amount of any outstanding claims.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this office to file a copy of this agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Chiro+Plus to endorse/sign my name on any and all checks listing me as a payee which are presented to this office for payment of an amount relating to me, my spouse, or my dependents, regardless of whether these charges are related to my condition.

I understand that I remain personally responsible for the total amounts due to Chiro+Plus for their services. This agreement does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take action to collect an outstanding balance on my account, I will be responsible for payments and will reimburse Chiro+Plus for all for all costs of collection efforts, including, but not limited to all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual consent of Chiro+Plus and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of these authorizations conflict with the terms of this agreement.

I agree that each and every provision of this agreement is reasonably necessary for the protection of the rights and interests of Chiro+Plus and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (please print):_____

Patient Signature:_____ Date:__/__/__

Name of Custodial Parent or Legal Guardian (please print):_____

Parent/Guardian Signature:_____