

# CONFIDENTIAL PATIENT CASE HISTORY

## WELCOME TO OUR OFFICE!

Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent records and will help us get a better understanding of your overall health. THANK YOU!

### PERSONAL INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female Marital Status: S / M / D / W

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ How Many Children (Ages)?: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Who Referred You To Us?: \_\_\_\_\_

How Else Did You Hear About Us?: \_\_\_\_\_

### CURRENT PRIMARY HEALTH CONCERN

What is your main symptom?: \_\_\_\_\_

How long have you had this condition?: \_\_\_\_\_

Have you had this or similar conditions in the past?: \_\_\_\_\_

What do you think caused this condition?: \_\_\_\_\_

What position(s), if any, make it feel worse?: \_\_\_\_\_

What position(s), if any, make it feel better?: \_\_\_\_\_

Over time, is this condition:  Improving  Unchanged  Getting Worse?

Is this condition interfering with your:  Work  Sleep  Daily Routine Other: \_\_\_\_\_

Have you sought advice or treatment from other doctors or therapists for **this** condition?  Yes  No

If yes, list all doctors or therapists consulted for this condition (include approximate date of visit and diagnosis).

\_\_\_\_\_  
Name Date of visit Diagnosis

\_\_\_\_\_  
Name Date of visit Diagnosis

Describe any treatment you have had for **this** condition (include medication dosage and frequency?): \_\_\_\_\_

Family Medical Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

May we communicate our findings on your current health condition to the above provider(s)?  Yes  No

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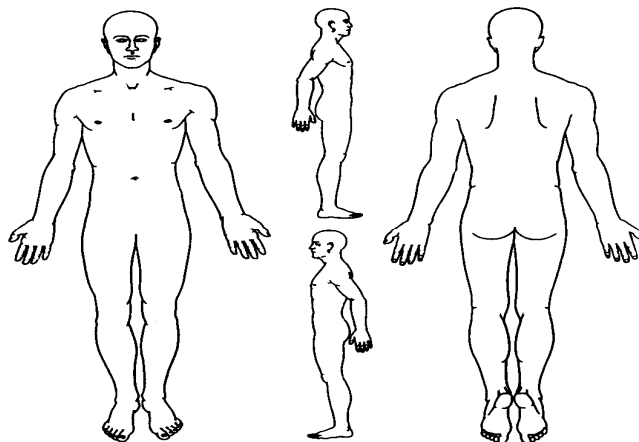
Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## OTHER HEALTH COMPLAINTS

Please list the specific complaints you are experiencing at this time and mark the location on the diagram. Beside each complaint, rate its severity on a scale of 1-10 with 1 being the least discomfort you have experienced and 10 being the most discomfort you have ever experienced.

Primary Complaint: \_\_\_\_\_

- 1) \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10  
Additional Complaints:  
2) \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10  
3) \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10  
4) \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10  
5) \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10



## PREVIOUS CONDITIONS

Days Lost From Work: \_\_\_\_\_ Date of Last Physical Examination: \_\_\_\_\_

Have you sought care for another health condition in the past year?  Yes  No Past 2 years?  Yes  No

If yes, what condition other than your primary complaint?: \_\_\_\_\_

Was treatment administered?  Yes  No Describe: \_\_\_\_\_

Do you take medications?  Yes  No List Dosage, Frequency and Reason: \_\_\_\_\_

Any prior hospitalizations or surgery?  Yes  No Describe with dates: \_\_\_\_\_

Have you been in an auto accident or had any other personal injury?  Yes  No Describe: \_\_\_\_\_

## CHIROPRACTIC HISTORY

Previous Chiropractic care?  Yes  No If yes, Doctor's name: \_\_\_\_\_

Date of last chiropractic visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last chiropractic X-rays: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for care: \_\_\_\_\_ How long were you under care?: \_\_\_\_\_

Were you satisfied with the previous chiropractic care you received?  Yes  No

Are other family members under chiropractic care?  Yes  No Who?: \_\_\_\_\_

Are you open to looking at new ideas in health and wellness?  Yes  No

## SOCIAL HISTORY

Height: \_\_\_\_ft. \_\_\_\_in. Current Weight: \_\_\_\_\_ lbs. Have you recently lost or gained more than 10 lbs.? Y N

Mental Work:  Heavy  Moderate  Light Hours per day: \_\_\_\_\_

Physical Work:  Heavy  Moderate  Light Hours per day: \_\_\_\_\_

Exercise:  Heavy  Moderate  Light Hours per week: \_\_\_\_\_ Type: \_\_\_\_\_

Smoking:  Never  Currently  Previously Packs/day: \_\_\_\_\_, Pack/week: \_\_\_\_\_ How long?: \_\_\_\_\_

Alcohol: Beer/week: \_\_\_\_\_, Liquor/week: \_\_\_\_\_, Wine/week: \_\_\_\_\_ How long?: \_\_\_\_\_

Caffeine: Cups/day: \_\_\_\_\_ How long?: \_\_\_\_\_ Aspirin: No./day: \_\_\_\_\_ How long?: \_\_\_\_\_

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Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## REVIEW OF SYSTEMS (NOW=within the past 1 year; PAST=over one year ago)

GENERAL	Now	Past	BREASTS	Now	Past	GENITOURINARY	Now	Past	PAST MEDICAL HISTORY
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>	Check only the ones you have had in the past.
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Spotting	<input type="checkbox"/>	<input type="checkbox"/>	
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever <input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>	Painful Menses	<input type="checkbox"/>	<input type="checkbox"/>	Mumps <input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever <input type="checkbox"/>
<b>SKIN</b>			Bloated	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	Allergies <input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	<b>RESPIRATORY</b>			Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>	Angina <input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer <input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<b>NEUROLOGICAL</b>			Tumor <input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease <input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia <input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble <input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hand Trembling	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins <input type="checkbox"/>
<b>HEAD &amp; EYES</b>			Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis <input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant exposure	<input type="checkbox"/>	<input type="checkbox"/>	Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension <input type="checkbox"/>
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<b>CARDIOVASCULAR</b>			Loss of Facial	<input type="checkbox"/>	<input type="checkbox"/>	Stroke <input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Weak Grip	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers <input type="checkbox"/>
Last Eye Exam	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice <input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Speech	<input type="checkbox"/>	<input type="checkbox"/>	Skin Trouble <input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones <input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>	Liver Trouble <input type="checkbox"/>
<b>EARS</b>			Chest Pain, Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis <input type="checkbox"/>
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<b>ENDOCRINE</b>			Parasites <input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy <input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis <input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<b>BLOOD</b>			Extremely Thin	<input type="checkbox"/>	<input type="checkbox"/>	Polio <input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness <input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>	Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism <input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Depression <input type="checkbox"/>
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Breast Changes	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Breakdown <input type="checkbox"/>
<b>NOSE</b>			Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>	<b>IMMUNIZATION/VACCINATION</b>			Migraine <input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>	DPT	<input type="checkbox"/>	<input type="checkbox"/>	Gout <input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids <input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Red Spots	<input type="checkbox"/>	<input type="checkbox"/>	Smallpox	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems <input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<b>GASTROINTESTINAL</b>			Typhoid	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Problems <input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea <input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis <input type="checkbox"/>
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes <input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>	Influenza	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Trouble <input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones <input type="checkbox"/>
<b>MOUTH</b>			Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	MMR	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infections <input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Irreg. Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>	<b>PSYCHIATRIC</b>			Dysentery <input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Hyperventilation	<input type="checkbox"/>	<input type="checkbox"/>	<b>ALLERGIES</b>
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Insecurity	<input type="checkbox"/>	<input type="checkbox"/>	List known allergies below
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Troubles Sleep	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Irritable	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>THROAT</b>			Black Stools	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<b>GENITOURINARY</b>			Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>	Drug Dependent	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal Thoughts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Straining	<input type="checkbox"/>	<input type="checkbox"/>	Extreme Worry	<input type="checkbox"/>	<input type="checkbox"/>	_____
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>	<b>MUSCULOSKELETAL</b>			
<b>NECK</b>			Stones	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>	
Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>	
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Small Stream	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	
Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	
Masses	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	

**If Female,  
Are You Pregnant?**  
 Yes  
 No

# CONFIDENTIAL PATIENT CASE HISTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## **FAMILY HISTORY - List any of the diseases listed previously which run in your family**

<b>Relative</b>	<b>Age if Living</b>	<b>Age at Death</b>	<b>Cause of Death</b>	<b>State of Health</b>	<b>Illnesses (if any)</b>
Father:	_____	_____	_____	_____	_____
Mother:	_____	_____	_____	_____	_____
Brother(s):	_____	_____	_____	_____	_____
Sister(s):	_____	_____	_____	_____	_____
Grandfather (Mat):	_____	_____	_____	_____	_____
Grandmother (Mat):	_____	_____	_____	_____	_____
Grandfather (Pat):	_____	_____	_____	_____	_____
Grandmother (Pat):	_____	_____	_____	_____	_____

Spouses Health Status:  Poor  Fair  Good  Excellent

Children's ages and health status: \_\_\_\_\_

## **INSURANCE INFORMATION**

Who is responsible for this account?: \_\_\_\_\_

Relationship to Patient?: \_\_\_\_\_ Social Security No: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Is patient covered by additional or secondary insurance?  Yes  No

Subscriber's Name: \_\_\_\_\_

Relationship to Patient?: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

## **ASSIGNMENT AND RELEASE**

I certify that if I, and/or my dependent(s) have insurance coverage, I will assign directly to this office 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. I understand that interest is charged on overdue accounts at the annual rate of 18%. I authorize the doctor or this office to contact me via mail, email and phone in regards to treatment as well as promotional activities. This clinic 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.

**I have also received a copy of this office's Financial Policy and Appointment Policy and agree to its terms.**

SIGNATURE of Patient, Parent or Guardian: \_\_\_\_\_

PRINTED Name of Patient, Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(A scanned copy of this document shall serve as the original.)

# AGREEMENTS and AUTHORIZATION

## Consent To Health Care Services/Release of Health Care Information

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient's behalf), hereby request and consent to Patient health care services from this office. The Patient health care services will be provided by and overseen by licensed, treating physicians. Health care services will also be provided by non-physician health care professionals and assistants employed or otherwise retained by this office. Medical, nursing, and other health care personnel who are in training may also participate in the Patient's care as part of their education.

\_\_\_\_\_ initial

## Payment Guarantee

In consideration of the services provided by this office, Provider to Patient, you agree to; I) guarantee payment of all charges incurred by Patient in connection with such services ("Patient Charges"); II) irrevocably assign and transfer to this office, all right, title and interest to medical reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and III) authorize payment of such benefits directly to this office. You also agree to be fully responsible for the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits.

\_\_\_\_\_ initial

## Notice of Non-Coverage

If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. Your insurance does not pay for all of your healthcare costs, specifically as it relates to treatment in a chiropractic office. Your insurance policy will only cover services that it deems are "Medically Necessary" according to their specific guidelines. When you receive a service or item that your insurance policy does not cover, then you are personally responsible for the non-covered services at the time they were rendered (unless prior arrangements have been made). Specifically, your insurance policy will not allow payment for the following non-covered services and you will have to pay out-of-pocket the normal fee as listed below because they are routinely deemed not-medically necessary according to insurance guidelines: maintenance/wellness chiropractic care, nutritional supplements, therapeutic modalities used for maintenance, massage and any service beyond your benefit plan visit limitations or services that are excluded from the benefit plan.

\_\_\_\_\_ initial

## Patient Right To Restrict Disclosure of Protected Health Information (PHI)

For any service in which you pay for 100% out-of-pocket, you have a right to restrict the disclosure of that healthcare information for that particular service to any health insurance entity. This is according to your HIPAA privacy rights established under the American Recovery and Reinvestment Act (ARRA) of 2009. For services that are non-covered under your insurance plan and that you pay for in-full out-of-pocket, you understand and request that this office does not bill for any of these non-covered services or items on my behalf and that you wish to restrict the disclosure of PHI of these services from your insurance company.

\_\_\_\_\_ initial

## Responsibility For Personal Property

You accept sole responsibility for all Patient property, except for property expressly accepted by this office for safekeeping under its sole care and custody.

SIGNATURE of Patient, Parent or Guardian: \_\_\_\_\_

PRINTED Name of Patient, Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# **AUTHORIZATION and HIPAA PRIVACY NOTICE**

## **Consent To Release Information**

Here at this office, we do not sell or release your information to third parties. There will be cases along the course of your care where information will need to be released in certain circumstances. You authorize this office to release to employer groups, government agencies (Medicare, Medicaid, Champus, State or Federal government, etc.), insurance companies, or other third-party payers and their agents, and its collection representatives and attorneys, the following "Patient Information": medical history, diagnosis and procedures performed, course of treatment, plan of care, prognosis, supplies and/or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization/payment for Patient's health care services, or billing and collection of amounts due to this office for services rendered. In the case of Patient Information released for purposes of payment of Patient Charges, this authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual health care professional, including treating physician(s), to provide this office or its designee with Patient Information for quality assurance and, or risk management purposes. Finally, in the event that the Patient's employer, or an insurance company representing such employer, requests Patient Information relating to healthcare services provided for worker's compensation injuries, it is understood and agreed that this office is required, under state law, to release copies of such information to such employer or insurance company without the authorization of Patient or Patient's representative. Again, here at this office, we strive to provide you with the best care possible and in order to do that this consent is necessary.

\_\_\_\_\_ initial

## **HIPAA Privacy Notice Patient Acknowledgment**

### **Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information**

I hereby state that by signing this Consent I acknowledge and agree as follows:

- 1) The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request and that a copy of it is always available at the Front Desk.
- 2) The Practice's Privacy Notice has been provided to me prior to my signing this Consent and a copy of it has been shown to me at the Front Desk. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations.
- 3) The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.
- 4) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
- 5) The Practice's "Notice of Privacy Practices" is also provided in the reception area display table and on the Practice's web site. I may also request a copy from this office at any time via US Mail.

This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

\_\_\_\_\_ initial

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

PRINTED Name of Patient, Parent or Guardian: \_\_\_\_\_

SIGNATURE of Patient, Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_