APPLICATION FOR CARE AT CHIROPRACTIC ASSOCIATES

PATIENT DEMOGRAPHICS How did you hear about us_____

Name: _____ Birth Date _____-_____-_____ Age: _____ ( ) Male ( ) Female

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Email Address: _____

Social Security # _____-_____-_____ Driver's License # _____

Are you currently Pregnant: YES NO If yes how many weeks?_____ Occupation: _____

Emergency contact Name & Phone Number: _____

Do you have Insurance? ( ) Yes ( ) No Company: _____

Relationship to Subscriber: ( ) Self ( )Parent ( ) Spouse

Subscriber Name _____ Subscriber DOB_____

Subscriber's address if not the same as yours:_____

HISTORY OF COMPLAINT

Please circle your complaint regions: Headache Neck Mid-back Low-back Sciatic Other:_____

Location: Left Right Both When did the problem(s) begin? _____

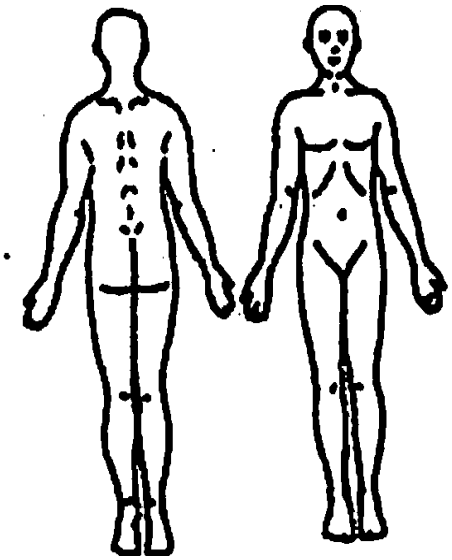
Frequency? ( ) It is Constant ( ) Frequent ( ) Intermittent ( ) Occasional

How did the injury happen? _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by circling the number:

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

***PLEASE MARK the areas on the diagram of the complaint areas.**



Complaint Details:

Symptoms (please circle): Aching Burning Dull Sharp Stabbing Throbbing Tightness Weakness Numbness Tingling
Radiating into:_____ Other:_____

What makes them feel worse? Heavy activity Moderate activity Light activity Bending Lifting Temp. changes Twisting
Other:_____

What relieves your symptoms? Ice Heat RX OTC - Med. Posture Changes Rest Stretching Support brace Activity level Nothing
Other:_____

Any activities you are not able to do at this time?_____

Is your problem the result of ANY type of accident? ( ) Yes ( ) No IF YES, please explain: _____

_____

Identify any other injury(s), minor or major, to your spine that the doctor should know about:_____

_____

PAST HISTORY

Have you tried any other forms of treatment? ( ) Yes ( ) No IF YES, please state the type of treatment: _____
_____, who provided treatment: _____
How long ago? _____

If you have ever been diagnosed with any of the following conditions, please indicate with a P for PAST, C for CURRENTLY have and N for NEVER have had:
___Broken Bone ___Dislocations ___Tumors ___Rheumatoid Arthritis ___Fracture ___Disability ___Cancer
___Heart Attack ___Osteo Arthritis ___Diabetes ___Cerebral Vascular ___Other serious conditions: _____

Please identify ALL PAST and CURRENT conditions you feel may be contributing to your present problem:
Past medical history : ( ) Injury ( ) Surgeries ( ) Child hood Diseases ( ) Adult Diseases

FAMILY HISTORY

Does anyone in your family suffer with the same condition(s)? ( ) Yes ( ) No
IF YES WHOM? ( ) Grandmother ( ) Grandfather ( ) Mother ( ) Father ( ) Sibling ( ) Child

AUTHORIZATION FOR RADIATION

(For Both Female and Males)

I understand that my condition may require my doctor to take X-Rays to further diagnose my symptoms and I give my permission for all needed diagnostic test.

Patient/Guardian's Signature _____ Date _____

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. Russell D. Blackwell and staff to administer treatment as he so deems necessary for my

_____ , _____.
(Child, grandchild, etc.) (Name of Minor Child)

Signature _____ Date _____
Witness _____ Date _____

_____ _____-_____-_____
Doctor's Signature **Date Form Reviewed**

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 affect 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.

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

Patient Signature _____ Date _____

PREGNANCY WARNING AND CONSENT TO X-RAY * Female ONLY !!

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are NOT pregnant at this time?

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

( ) There is a possibility that I may be pregnant at this time
( ) Yes. I am definitely pregnant at this time.
( ) No. I am definitely NOT pregnant at this time.
( ) I request that x-ray films not be taken because _____.

Date of last menstrual period: _____

Signature _____ Date _____

Billing/Payment Policy:

As a healthcare practice, our goal is to provide you with the best possible care. As a small business, we strive to be patient friendly and cost effective. Payment is expected at the time of service. If you have insurance, we provide the service of submitting your claims. Determining the cost of a visit when you use insurance is quite difficult as each policy can have a different co-payment, co-insurance or deductible, and our contracted rates vary with every insurance contract. Note that the balance of your claim is your responsibly whether or not your insurance pays your claim. If your insurance changes, it is your responsibility to notify us. Please contact your insurance company with any questions about your coverage.

Note your Doctor does/will not discuss covered services, payments or balances with patients, as they concentrate their efforts on your healthcare. Please consult with the front desk staff with any questions/concerns you may have.

Our practice is committed to providing excellent treatment to our patients. Thank you for understanding our office and billing/payment policies.

I have read and understand the office and billing/payment policies.

Signature:_____ Date:_____

Parent/Guardian:_____ Date:_____

Collections Policy

Once your account goes past due we send out three statements to the address we have on file. The third statement sent being the final statement. If no payment is made within 30 days of the final statement sent the account will be sent to CBSA Solutions. (Our Collections agency) You will then have to pay your balance to CBSA. Solutions.

By signing I authorize CBSA Solutions to contact me via current/future phone number(s), email addresses or wireless devices regarding my delinquent account(s) I owe Chiropractic Associates . I authorize CBSA and it's agents, attorneys (including collection agencies) to use automated telephone dialing equipment, artificial or prerecorded voice/text message and personal calls or emails, in their effort to contact me for purposes of collecting any portion of my account which is past due.

I/We have read this disclosure and agree to the terms described above

Signature:_____ Date:_____

Parent/Guardian:_____ Date:_____

AUTHORIZATION FOR CARE GENERAL RELEASE AND ASSIGNMENT OF BENEFITS TO CHIROPRACTIC ASSOCIATES

AUTHORIZATION FOR CHIROPRACTIC TREATMENT: I, the undersigned, a patient in this Office, hereby authorize CHIROPRACTIC ASSOCIATES, and all employees (including doctors of chiropractic) to administer such treatment as deemed necessary by the doctor. I also certify that no guarantee or Assurance has been made as to the results that may be obtained. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.
I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

GENERAL RELEASE OF INFORMATION: I hereby authorize any hospital, physician or other person who has examined or attended me, to furnish to CHIROPRACTIC ASSOCIATES or a representative thereof, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. I hereby authorize CHIROPRACTIC ASSOCIATES to release to authorized persons any and all records pertaining to my treatment in said clinic.

ASSIGNMENT OF BENEFITS: I hereby authorize the direct payment to CHIROPRACTIC ASSOCIATES of any sum I now or hereafter owe them by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or them based in whole or in part upon the charges made for their services. I understand that (regardless of my insurance carrier), I am ultimately financially responsible for the balance on my account for any professional services rendered, whether or not paid by said insurance. I understand and agree to allow this office to use the Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. 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 become immediately due and payable in full by you, regardless of any claims submitted.

In consideration of CHIROPRACTIC ASSOCIATES undertaking to treat me, I have read all of the above, understand, and agree to all consents and releases. These consents and releases will remain in effect until revoked by me in writing. A photocopy of this form is to be considered as valid as the original. I also have read all the information on this sheet, have answered all the questions and I certify that it is true and correct to the best of my knowledge. In addition, I declare that I will notify CHIROPRACTIC ASSOCIATES of any changes in my health status or the above information.

Patient Signature: _____Date: _____

Guardian's Signature Authorizing Care: _____Date: _____

Witness Signature (Office): _____Date: _____