Confidential Patient Data

IF YOU NEED ASSISTANCE IN COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION **Today's Date:____/____/_____ Date of Birth____/____/____**

Name:_____

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

Home Phone:(____)_____-_____ **Cell Phone:(____)_____-_____**

Work Phone:(____)_____-_____ **Email Address**_____

Social Security#:_____-_____-_____ **Age:**_____ ☐ **Male** ☐ **Female**

Name of Spouse or Nearest Relative:_____ **Phone:(_____)**_____

Number of Children:_____ **Your Employer**_____

Your Occuaption:_____

Weight Frequently Required to Lift is under 10 20 30 40 **lbs.**_____

Refered to this office by: ☐**Physician-Who**_____

☐**Friend-Who**_____ ☐ **TV** ☐**Screening-Where**_____

☐**Yellow pages** ☐**Direct Mail** ☐**Clinic Location** ☐**News Paper** ☐**Other**

Payment for services will be by ☐**Private Pay (Uninsured)** ☐**Health Insurance**

☐**Automobile Insurance**

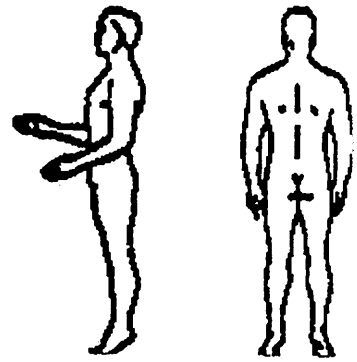
Name of Insured:_____

Insured's Employer:_____

Insured's date of birth:____/____/_____ **Insured's Social Security#:**_____/____/_____

Are you covered by more than one insurance company? ☐**YES** ☐**NO**

Name of company_____ **ID#:** _____



Please describe present major complaints in order of severity:

1. _____

2. _____

3. _____

Do you have numbness radiating down your ☐arms ☐hands ☐legs ☐feet

Symptoms are worse in ☐Morning ☐Afternoon ☐Night

When and how occurred?

_____

Symptoms developed from : ☐job related injury If so did you report to employer? ☐Yes ☐NO

☐Auto Accident ☐Other ☐Accident ☐Illness ☐Unknown Cause ☐Gradual Onset

Date occurred:_____/_____/_____

Symtoms have persisted for # _____ Hour(s) _____Day(s) _____Week(s)_____Month(s) _____ Year(s)_____

Symptoms/complaints: ☐come and go ☐are constant

Have you ever had this before: ☐No ☐Yes When?_____

If you were to guess, what do you think is causing your complaints?_____

_____

Name and location of doctors previously seen for present conditions:_____

_____

Are you taking any medication ☐No ☐Yes What kind?

_____

Are you pregnant ☐No ☐Yes Date of last menstrual period _____/_____/_____

Please check the following activities that aggravate your condition: ☐bending ☐reaching ☐straining at stool ☐coughing ☐sitting ☐turning head ☐lifting ☐sneezing ☐walking ☐lying down ☐standing

Please check the following activities that relieve your condition: ☐bending ☐sitting ☐lifting ☐standing ☐lying down ☐turning head ☐reaching ☐walking

When it's at it's worst, how does it interfere with your normal daily activities?_____

_____

Does this problem reduce your productivity or effectiveness regarding your work?_____

_____

Does it create problems in your relationships? ☐Yes ☐No

Your favorite sleeping posture:_____

s your sleep..... ☐difficult ☐restful ☐sufficient How many hours_____

Please check any additional symptoms you may be experiencing:

☐Blurred vision ☐buzzing in ears ☐cold feet ☐cold hands ☐cold sweats ☐concentration loss/confusion
☐constipation ☐depression/weeping spells ☐diarrhea ☐dizziness ☐excessive flow ☐face flushed
☐fainting ☐fatigue ☐fever ☐frequent urination ☐head seems too heavy ☐headaches ☐insomnia
☐irregular cycles ☐light bothers eyes ☐loss of balance ☐loss of smell ☐loss of taste ☐low back pain
☐low resistance to colds ☐muscle jerking ☐numbness in arms hands or fingers ☐numbness in toes
☐pain between shoulders ☐painful urination ☐ringing in ears ☐sensation of pins and needles in arm
☐sensation of pins and needle in legs ☐shortness of breath ☐stiff neck ☐stomach upset

Why do you think chiropractic can help you?_____

How long do you think it will take chiropractic to help you?_____
Do you have any concerns or apprehension in your decision to seek our services?_____

Patient's signature:_____ Date_____/_____/_____

MEDICAL / FAMILY HISTORY

S=SELF M=MOTHER F=FATHER

(Please indicate which conditions have been experienced by the above by marking the appropriate boxes.)

S	F	M		S	F	M		S	F	M	
☐	☐		Aids	☐	☐	☐	Convulsions	☐	☐	☐	Kidney Disorders
☐	☐		Allergy	☐	☐	☐	Diabetes	☐	☐	☐	Menstrual Cramps
☐	☐		Anemia	☐	☐	☐	Dislocated joints	☐	☐	☐	Multiple Sclerosis
☐	☐		Arthritis	☐	☐	☐	Epilepsy	☐	☐	☐	Muscular Dystrophy
☐	☐		Asthma	☐	☐	☐	Fibromyalgia	☐	☐	☐	Neck Pain
☐	☐		Back Pain	☐	☐	☐	German Measles	☐	☐	☐	Nervousness
☐	☐		Bladder Trouble	☐	☐	☐	Headaches	☐	☐	☐	Numbness
☐	☐		Bone Fracture	☐	☐	☐	Heart Trouble	☐	☐	☐	Polio
☐	☐		Bowel control loss	☐	☐	☐	Hepatitis	☐	☐	☐	Poor Circulation
☐	☐		Cancer	☐	☐	☐	High Blood Pressure	☐	☐	☐	Rheumatism
☐	☐		Chest Pain	☐	☐	☐	HIV/ARC	☐	☐	☐	Reproductive Disorders
☐	☐		Concussion	☐	☐	☐	Indigestion	☐	☐	☐	Sinus Trouble

Have you been treated by a physician for any health condition in the last year? ☐yes ☐No

Describe condition_____

Date of last physical exam_____/_____/_____

Surgical History

_____ **Date**_____/_____/_____

_____ **Date**_____/_____/_____

Accident History

Job Auto Other_____ **Date**_____/_____/_____

Job Auto Other_____ **Date**_____/_____/_____

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

X _____ _____

Printed Name — Authorized Provider Representative

X _____ _____

Signature — Date

_____

Date

ASSIGNMENT OF PAYMENTS/BENEFITS

I hereby authorize assignee to release information necessary to secure my care at facility. I have voluntarily presented myself for treatment.

I hereby assign payment of my benefits, including major medical benefits to which I am entitled, private insurance and any other health plan to:

Dr. Joseph Crum

Appalachian Chiropractic Wellness Center
111 Commonwealth Avenue, Suite 120
Bristol, VA 24201
(276) 669-0969

A photocopy of this assignment is to be considered as valid as an original. This assignment will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that this office files primary insurance only.

If this account is placed in the hands of an agency or attorney for collection or legal action, additional charges equal to the cost of collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions will be added to the amount due.

Please authorize with your:

Signature_____

Date_____

Please present your driver's license and insurance identification card to our receptionist to photocopy for your permanent office record.

THANK YOU!

Appalachian Chiropractic Wellness Center
111 Commonwealth Avenue
Bristol, VA 24201
(276) 669-0969

OFFICE/PATIENT COMPLIANCE POLICIES

1. Keep your appointment as scheduled. There will be a *$10.00* charge added to your account for any missed appointment. Notification of cancellation must be received **twenty four hours prior to appointment** to avoid *$10.00* charge.

2. Our office files **primary** insurance only.

3. Our office is pleased to accept your primary insurance assignment, **however it must be fully understood that the contract is between you and your insurance company.** We will be happy to explain your benefits to you, **but it is your responsibility to be aware of and acknowledge your insurance benefit limitations**.

4. If supplies are necessary we will gladly file primary insurance for them, but we must collect for them in full at the time of service.

5. Allow us ample time for stabilization. (Time is a very important part of regaining you health).

6. Please inform us before you seek any other medical or home type of care during spinal correction.

7. Other care, treatments, or drugs may alter your progress and ultimate recovery.

8. Since this office is a busy one, please be patient if we are behind schedule. If you must go to work, or are on your lunch break, or have another appointment, please let us know and we will try to accommodate you. If you have to wait when you come in the office, remember, you will receive the same careful attention as those before you.

*Yours For **Better health**,*

Joseph M. Crum, D.C., and Staff

*PATIENT SIGNATURE*_____ *DATE*_____

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient name printed Date

_____ _____

Patient Signature Authorized provider representative

_____ _____

Personal representative Printed Personal representative signature

_____

Description of personal representative's authority to act for the patient.