PATIENT HISTORY

Date: _____ Referred By: _____
Name: _____ Email: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____ Cell: _____
Birth Date: _____ Sex:___ Age: _____ Marital Status: _____ # of Children: _____
Occupation: _____ Employment: _____ Work Phone: _____
Social Security Number: _____ Drivers License #: _____
Policy holder Name: _____ Policy holder DOB and SSN: _____

PLEASE FILL IN THE APPROPRIATE SPACES (All information you give is confidential):

MAJOR COMPLAINT _____

_____

How long have you had this condition? _____
Date Began: _____
Have you lost work days: Yes ( ) No ( ) How many? _____
Have you had this similar condition before? Yes ( ) No ( ) When? _____
Was the injury related to: work accident ( ) auto accident ( )
When did you last see a Chiropractor: _____ Dr.: _____
Why did you see this Chiropractor? _____ Were you helped? _____
What spinal maintenance programs were you given to follow to maximize the future stability of your spine? _____

_____

Did you follow it? _____ If not, why? _____
Why are you changing Chiropractors? _____

PAST (O) OR PRESENT (X) CONDITIONS:

_____ Fractured Bones
_____ Auto Accidents
(a)_____ 0-1 years ago
(b)_____ 1-5 years ago
(c)_____ More than 5 years ago
_____ Other Accidents/Falls
_____ Knocked Unconscious
_____ Back Curvature
_____ Mental or Emotional Disorders
_____ Arthritis
_____ Diabetes
_____ Swollen or Painful Joints
_____ Convulsions/Epilepsy
_____ Skin Problems
_____ Itching
_____ Bruise Easily
_____ Cancer
_____ Frequent Colds/Flu
_____ Nervous
_____ Tension
_____ Depressed
_____ Irritable
_____ Anemia
_____ Excess Sweating
_____ Tremors
_____ Light Bothers Eyes
_____ Allergy
_____ Sinus Problems
_____ Light Headed upon Rising
_____ Under stress
_____ Crave Sweets or Salt
_____ Eating disorders
_____ Trouble Sleeping
_____ Trouble concentrating
_____ Loss of Memory

_____ Learning Disability
_____ Mistake sidedness (R from L)
_____ Stutter
_____ Dyslexia
_____ Mood Changes
_____ Lose Temper easily
_____ Headache
_____ Neck pain or stiff R L
_____ Numbness, tingling, or pain in arms, hands, fingers R L
_____ Jaw pain or click (T.M.J.) R L
_____ Head seems too heavy
_____ Head & Shoulders feel tired
_____ Difficulty in excessive (standing, walking, sitting, riding, bending, lifting, twisting, household duties)
_____ Shoulder pain R L
_____ Dizziness
_____ Ringing in ears R L
_____ Hearing loss R L
_____ Fainting
_____ Loss of Balance
_____ Blurred or double vision R L
_____ Upper back pain or stiffness R L
_____ Mid back pain or stiffness R L
_____ Lower back pain or stiffness R L
_____ Numbness, tingling or pain in buttocks, thighs, legs, feet, toes R L
_____ Pain with cough, sneeze or strain at stools
_____ Hip pain R L
_____ Foot trouble R L
_____ Chest pain
_____ Asthma
_____ Lung problems
_____ Difficult Breathing

_____ Wheezing
_____ Heart Problems
_____ Stroke
_____ High or low blood pressure
_____ Varicose Veins
_____ Liver Trouble
_____ Gall Bladder trouble
_____ Digestive problems
_____ Excessive Gas
_____ Belching/bloating after meals
_____ Heartburn
_____ Ulcers
_____ Diarrhea/constipation
_____ Colon Trouble
_____ Hemorrhoids
_____ Prostate problems
_____ Impotence
_____ Kidney trouble
_____ Kidney stones
_____ Frequent urination
_____ Discharge
_____ Menstrual problems/PMS
_____ Menopausal problems
_____ Breast lumps, soreness or discharge
_____ Pregnant (now)
_____ Bedwetting
_____ Ear infections
_____ Hepatitis
_____ Venereal Disease
_____ AIDS/HIV
_____
_____
_____
_____

WHAT ARE YOUR HEALTH GOALS? (What will motivate you to reach these goals?) _____

_____

_____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

_____ Temporary Relief (Help the symptom but do not fix the cause of the problem)

_____ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

WHY DID YOU COME INTO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US? _____

_____

1. What are your favorite hobbies or activities to do now? _____
2. Are you current problems affecting these activities or hobbies? _____
3. What activities are you looking forward to doing in the future? _____
4. Who would you like to be doing these with? _____

On a scale of 1-10 (10 being the most and 1 being the least),
_____ How committed are you at being at your maximum health potential?
_____ How important is it for your family to be at their optimum health potential?
_____ How committed are you to preventing arthritis and maximizing your spinal stability?

What surgeries have you had? _____

List drugs you now take (prescription and non-prescription): _____
_____

Name other doctors you have seen for this condition: what was done, and for how long?
_____
_____

Are you currently wearing: Heal lifts ( ) Arch Supports ( )

X-Ray Consent

I do here by give my consent to allow the clinic of Family Care Chiropractic and its representatives to take x-rays as deemed appropriate by examining Doctor of Chiropractic. I also hereby declare that to my knowledge that I am NOT pregnant.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give my authority for these procedures to be performed. It is understood and agreed the amount paid to the facility 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.

Signed: _____ Date: _____

Printed: _____ Date: _____

Family Care Chiropractic
Dr. Kimberly Harper

WE ARE COMMITED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE, AND WE ARE HAPPY TO DISCUSS OUR PROFESSIONAL FEES WITH YOU AT ANY POINT. YOUR CLEAR UNDERSTANDING OF OUR FINANCIAL POLICY IS IMPORTANT TO OUR PROFESSIONAL RELATIONSHIOP. PLEASE ASK IF YOU HAVE ANY QUESTIONS ABOUT OUR FEES, FINANCIAL POLICY OR YOUR RESPONSIBILITY.

All patients must complete our "Patient Information", "Consent/HIPPA" and "Financial Policy" forms including initials, signatures, and date before seeing the doctor.

RESPONSIBLE PARTY:

- Payment is due in full at the time of service IF you do not have health insurance or can provide our office with adequate billing information.
- All patients are responsible for any co-payments, deductibles, non-covered services, or supplies at the time service is rendered. Federal and Managed Care contract laws require this office to collect co-payments for each encounter
- You will be responsible for charges regardless of divorce decree or court order regarding payment of medical bills.
- Time is valuable. Please be respectful and courteous and respect your appointment time. **No show appointments may be subject to $25 charge. All no show appointment fees are donated to Riley Children's Hospital.** We understand emergency situations, but adherence to the prescribed treatment plan is vital to your progress with Chiropractic care. Make up appointments should be scheduled in the same week. We appreciate your cooperation!
- **Your account will be charged $25 for each time a check is returned for non-sufficient funds.** If these checks are not honored by your bank, you will be responsible for the payment of the check and additional charges within 10 days.

_____ **Initials**

REGARDING INSURANCE:

- Insurance is a contract between you and your insurance company. you understand that it is your responsibility to know your insurance benefits and make sure that your insurance company pays their portion in a timely manner. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, cover charges, secondary insurance, "usual and customary charges", etc. other than to supply factual information as necessary. **You are responsible for timely payment of your account.**
- If your insurance information changes at anytime during treatment it is your responsibility to provide us with the current accurate information. Family Care Chiropractic cannot be responsible for any penalties or denial of payment as result of incorrect insurance information.

- If your insurance requires a referral from your primary care physician, it is your responsibility to obtain that prior to services rendered. IF you arrive at our office without a referral and are unable to obtain by phone at the time, it is your responsibility to pay in full at the time of service. Should you require ancillary service (such as diagnostic testing), please be familiar with your insurance policy.
- Please advise our staff if your insurance company has special requirements such as pre-certification or second opinions prior to treatment. We do all we can to help, but the ultimate responsibility for fulfilling special requirements rest with the patient. Being familiar with your insurance benefits will help avoid payment misunderstandings.

_____ **Initials**

COLLECTION POLICIES:

- Should you need to make payment arrangements; you will need to sit down with our account manager to agree upon a payment schedule
- **Should your account become delinquent, we will place the account with a collection agency, and you will be responsible for the collection fees equaling 28% of any unpaid balance placed for collection. After 90 days delinquent account balances may be subject to a 3% interest charge accrued monthly. Additionally, if an attorney is engaged to pursue collection of the account, you will also be responsible for all reasonable attorney fees, court costs, sheriff or service of process fees and any other reasonable costs of collection.**

_____**Initials**

I, the undersigned, have read, understand, and agree to abide by the above information. I authorize payment of medical benefits to Family Care Chiropractic for any services rendered to me. I understand that I am financially responsible for any amount not covered by insurance.

_____

Patient/Parent/Guardian Signature

_____

Date

Dr. Kimberly S. Harper, D.C.

FAMILYCARE CHIROPRACTIC
"Caring for you and your Family"

Assignment of Benefits/HIPAA Form

Release of medical information and authorization to pay insurance benefits: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician on my behalf.

INITIALS_____

HIPPA (Health Information Portability and Accountability Act): I have received or been offered a copy of the Notice of Privacy Practices for protected health information.

INITIALS_____

HIPAA – Patient authorization for appointment reminders, scheduling related matters, chiropractic care, related health services and/or health related products.

INITIALS_____

Health and Medical Release

I, _____, give permission to Dr Kimberly Harper, associates, and employees of Family Care Chiropractic to share private and medical information with my medical doctor, _____, as well as his/her employees and associates. My medical doctor, as well as his/her employees and associates have permission to share personal and medical information with Dr Harper and her staff.

Medical Doctor Information

Name of Doctor: _____

Address: _____

City, State, Zip: _____

Phone: _____

Patient Signature: _____ Date: _____