Patient Information

Date: _____

Personal Information:

Name: _____ Soc. Sec. #: _____

Date of Birth: _____ Age: ___ Sex: M F Marital Status: S M D W

Mailing Address: _____ City: _____ State: ___ Zip: _____

Physical Address (no PO Box): _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ email: _____

Whom will we be contacting if we call? Self, or _____

Employer: _____ Occupation: _____

Referred by: _____ Past Chiropractic care? Y N When?: _____

Family Information:

Partner/Guardian's name: _____ Soc. Sec. # _____

Employer: _____ Work Phone: _____

Insurance Information:

Insurance Carrier: _____ Policy #: _____

Group #: _____ Effective Date: _____

Relationship to Insured: Self Spouse Child Other

Patient's or Authorized Person's Signature:
I authorize the release of any medical or other info necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

X_____ Date:_____.

Insured or Authorized Person's Signature:
I authorize payment of medical benefits to Summerville Chiropractic for performance of Chiropractic services:

X_____ Date:_____.

Payment Information:

Method of payment (circle one): Insurance Cash Check Credit Card M/C Visa Discover # _____

Party responsible for payment: _____

Are you interested in our payment plan options? Yes No

If treatment is for a minor, who is responsible for payment? _____

Payment is due at the time services are rendered. As a service and courtesy to our patients, we currently file any insurance that provides coverage for Chiropractic care. In the event that your carrier denies payment, or when maximum benefits have been reached, you will be responsible for your account balance. It is understood and agreed that the amount paid for X-Rays is for examination only, and the X-Ray films will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

_____ _____

Signature Date

Hello! In order to be government-compliant for the Electronic Health Records (EHR) requirement, we need all of our patients to fill this out completely.

---Thank you, and if you have any questions, please ask!

Today's Date: _____ Your Full Name: _____

Medications: (Vitamins and herbs come on the next page)

_____ I am not taking any medications at this time (Excellent - good for you!)

List current medications including dosage and how often you take it (daily, twice daily, etc). Also, we need to know how long you have been taking it (approximately --- like 6 months, or 3 years, best you can recall)

--example--- Xanax, 1mg, once a day in the morning, for 2 years

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

(If you need more room, please use the back. Thank you.)

Vitamins (supplements) and Herbs:

_____ I am not taking any vitamins, supplements, or herbs at this time

Please list current items including dosage, Brand name, how often you take it (daily, twice daily, etc), and do you take it with water or not.

--example--- Vit D, Natures Pure brand, 1000 iU, once a day in the morning, with water

1)_____

2)_____

3)_____

4)_____

5)_____

Allergies:

_____ I am not allergic to anything that I know of
-or- These are the MEDICINES or FOODS I am allergic to: (only need info on those 2 things) :

_____ _____ _____

Has any immediate family member ever had any of the following?

(*Please circle and write family member on line*)

Heart Diseases:

- Angina _____
- Heart Attack _____
- Coronary Artery _____
- Bypasses (other) _____
- High Blood Pressure _____

Diabetes:

- Type 1 _____
- Type 2 _____

Lung issues:

- Asthma _____
- COPD _____
- Emphysema _____
- Pneumonia _____

Stomach/Digestion problems:

- Colon trouble _____
- Irritable Bowel _____
- Acid reflux (GI disorder) _____

Alzheimer's _____

High Cholesterol _____

Osteoporosis _____

Stroke _____

Cancer _____ **TYPE or WHERE** _____

Depression _____

Has any doctor diagnosed you with Hypertension (high blood pressure) ? ___ Yes ___No

Has any doctor diagnosed you with Diabetes ? ___ Yes ___No

If yes, what kind? Type I or II ?

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes__ No __ Not Sure___

Has any doctor diagnosed you with any type of significant health syndrome presently? Yes__ No__ Not Sure___

If yes, what kind? _____

Have you had an X-ray, CT scan, or MRI of your low back spine in the past 28 days? Yes ____ No ____

☺ ☺ ☺ ☺ ☺

To be performed by clinic staff:
Height:____ ____**inches Weight:** _____**pounds BP:** _____/_____ **L R Date taken:** _____

For Office Use Only:
Past DC: Y N
S M D W
City: _____
Ref by: _____

Health History

Date: _____

Name: _____ Age: _____

Employer: _____ Occupation: _____

Reason for seeking Chiropractic Care:

Major Complaints and Symptoms:

_____

_____

When did you first notice this? _____ Has this happened before? Yes □ No □

If yes, when? _____ Any family history of this condition? Yes □ No □

Does this interfere with normal living and/or work? Yes □ No □

Was it caused by a: (circle one) Strain □ Fall □ Accident □ Emotional Shock □

Have you had treatment by another doctor for this? Yes □ No □ By: MD □ Chiropractor □

Name of Doctor: _____ Diagnosis: _____

What type of treatment did you receive? _____

Length of time under doctor's care: _____ Results: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES? (*Please check)*

□ Polio	□ Lumbago	□ Appendicitis	□ Heart Disease	□ Anemia	□ Sciatica
□ Alcoholism	□ Scarlet Fever	□ Measles	□ Epilepsy	□ Tuberculosis	□ Typhoid Fever
□ Mumps	□ Diabetes	□ Chicken Pox	□ Rheumatic Fever	□ Cancer	□ Pleurisy
□ Pneumonia	□ Venereal Infection	□ Goiter	□ Malaria	□ Rheumatism	□ Mental Disorders
□ Flu	□ Small Pox	□ Diphtheria	□ Whooping Cough	□ Cholera	□ Arthritis

OPERATIONS: _____None, or:

Date _____ Tonsillectomy	Date _____ Appendectomy	Date _____Hernia
Date _____ Gall Bladder	Date _____ Female Organs	Date _____Thyroid
Date _____ Back or Neck	Date _____ Colon / Rectum	Date _____Stomach
Date _____ Heart	Date _____ Knee/Leg/Ankle	Date _____Wrist/Arm
Date _____ Sinus	Date _____ Skin	Date _____Shoulder

Others not listed above (with date): _____

Please check all of the following symptoms and signs which you now have or have had within the last 6 months. An understanding of your health status will help facilitate care.

GENERAL SYMPTOMS:

□ Headache
□ Fever
□ Chills
□ Night Sweats
□ Fainting
□ Dizziness
□ Convulsions
□ Loss of sleep
□ Loss of weight
□ Numbness or pain in arms, legs or hands
□ Allergy (what)
□ Wheezing
□ Neuralgia
□ Fatigue

MUSCLE & JOINTS

□ Weakness
□ Twitching
□ Stiff neck
□ Backache
□ Swollen joints
□ Tremors
□ Foot trouble
□ Painful tail bone
□ Pain between shoulders
□ Hernia
□ Spinal curvature

GASTRO-INTESTINAL:

□ Poor appetite
□ Poor digestion
□ Excessive hunger
□ Belching or gas
□ Nausea
□ Vomiting
□ Vomiting blood
□ Pain over stomach
□ Constipation
□ Diarrhea
□ Colon trouble
□ Hemorrhoids (piles)
□ Gall Bladder trouble
□ Regular bowel movement
□ Jaundice

CARDIO-VASCULAR

□ Rapid heart
□ Slow heart
□ High blood pressure
□ Low blood pressure
□ Pain over heart
□ Previous heart trouble
□ Swelling of ankles
□ Poor circulation
□ Varicose veins
□ Strokes

EYE, EAR, NOSE, THROAT:

□ Poor vision
□ Crossed eyes
□ Pain in eyes
□ Deafness
□ Earache
□ Ear noises
□ Nasal obstruction
□ Nose bleeds
□ Sore throat
□ Hoarseness
□ Hay fever
□ Enlarged thyroid
□ Frequent colds
□ Tonsillitis
□ Sinus Trouble

SKIN OR ALLERGIES

□ Skin eruptions
□ Itching
□ Bruising easily
□ Dryness
□ Boils
□ Sensitive skin
□ Hives or allergies
□ Eczema
□ Medicines

EXERCISE:

□None □Moderate □Daily

RESPIRATORY:

□ Chronic cough
□ Spitting blood
□ Spitting phlegm
□ Chest pain
□ Difficulty breathing
□ Bronchitis

GENITO-URINARY

□ Frequent urination
□ Painful urination
□ Blood in urine
□ Kidney infection
□ Bed wetting
□ Inability to control urine
□ Prostate trouble

FOR WOMEN ONLY

□ Painful periods
□ Excessive Flow
□ Irregular cycles
□ Hot flashes
□ Cramps or backache
□ Miscarriages
□ Vaginal discharge
□ Pregnant at this time

HABITS

□ Smoking__packs per day
□ Drinking __Alcohol
□ Coffee __ cups per day

LIST ANY ACCIDENTS OR FALLS (even if minor, or not your fault, or long ago, or as a child):_____

_____

_____

BROKEN BONES OR DISLOCATIONS (FRACTURES): _____

_____

Have you ever had any epidurals or spinal injections? Yes □ No □ Were you ever knocked unconscious? Yes □ No □

Have you ever had X-Rays taken? _____ If so, when? _____ By Whom? _____

For what ailments were these pictures made? _____

Do you suffer from any condition other than that which you are now consulting us? _____

_____

Are you presently taking any medications, vitamins or herbs? (this includes Advil, Aspirin, Tylenol, etc) Yes □ No □

If so, what ones? _____

For which conditions? _____

I affirm that that the information provided here is accurate and true.

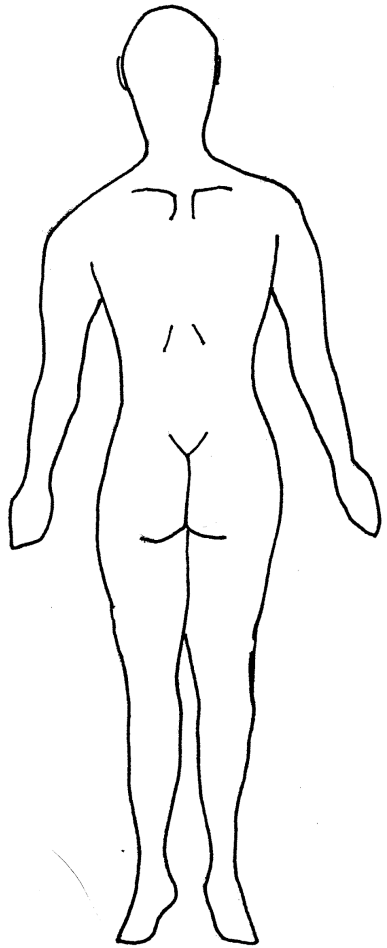
_____ _____

Signature Date

Patient #: _____ **Patient Name: _____** **Date: _____**

Please tell us where and how you hurt:

Use this scale to indicate how bad it is:
MILD – MODERATE – EXTREME
1 - 2 - 3 - 4 - 5



___ Sharp ___

___ Dull ___

___ Aching ___

___ Tingling ___

___ Numb ___

___ Hot / Burn ___

___ Cold ___

___ Catch ___

___ Crick ___

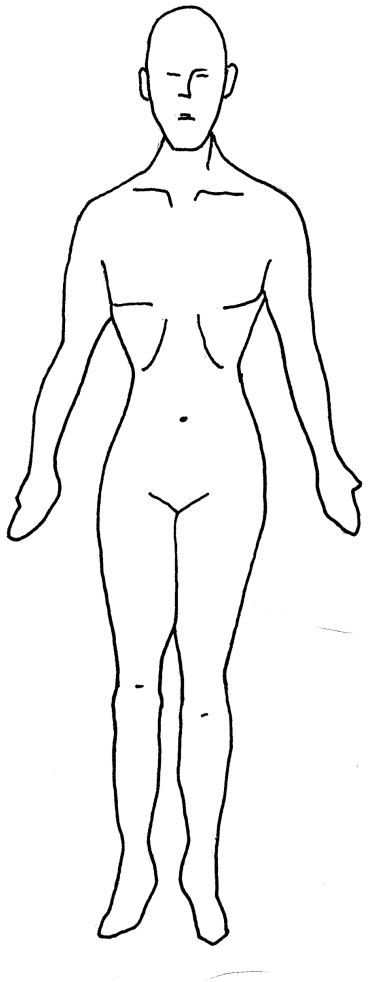
___ Cramp___

___ Stiff ___

___ Pressure ___

___ Limited Movement ___

___ Knifelike / Stabbing ___



Informed Consent

PATIENT NAME: _____

Please read this entire document prior to signing it. It is important that you understand the information. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement, or nothing at all.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- spinal manipulative therapy
- range of motion testing
- muscle strength testing
- hot/cold therapy
- radiographic studies
- palpation
- orthopedic testing
- postural analysis
- basic neurological testing
- vital signs

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are extremely rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare. The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Appelbaum and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ **Dated: _____**

Patient's Name:_____ **Doctor's Name: Dr. Jeff Appelbaum**

Signature:_____ **Signature: _____**

Signature of Parent or Guardian (if a minor): _____

Financial Policy – Medical Provider's Contract: Summerville Chiropractic

The established financial policy of this office is that payment is due at the time of service. We accept assignment of benefits on most major insurance policies.

**** Please understand that we are here to serve YOU, not your insurance company! ****
**** Talk to us if there is a money concern ****

Medicare:

While we are not a participating provider of Medicare services, Medicare will pay for 25 Chiropractic adjustments in a 365 day cycle. Thus we will accept assignment for that period (whichever comes first). You are responsible for the Medicare co-payment on each visit. We will file claims to Medicare every 2 weeks. They will not cover the cost of examinations or x-rays, although these services are required in order for Medicare to cover the cost of your adjustments. You will be responsible for the cost of exams and x-rays. If Medicare ceases to cover your Chiropractic care, we will set up an affordable monthly payment agreement with you.

Patients without Insurance:

It is **required** that you pay at the time of service on your first visit. In certain situations, we will set up a weekly or monthly payment plan for future services. Please speak with the office staff if you need this. We will work with you.

Patients with Insurance:

Regardless of whether or not you have met your deductible for the year, payment **must** be made for your initial visit. On your second visit, after we have verified your insurance policy coverage, we will speak to you regarding any credit balance you may have with us. Please remember Health Insurance policies are contracts between patients and their insurance companies. If you have qualifying insurance and sign our "Assignment of Benefits" form, we will prepare and file your claims and wait for up to 60 days for insurers to pay their portion of your claim(s). Under this arrangement, you must pay your deductible, co-pay, and any non-covered portion on **each visit**, or on a scheduled payment plan if you prefer.

Our charges are within the range considered "Usual & Customary" by most insurance carriers, however we cannot warrant or guarantee that your insurance will pay. Any services not covered, or coverage reductions by your insurance will be *your responsibility.* If coverage problems arise, you will be expected to deal with your insurance company, adjustor, or agent directly. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

- All insurance payments received are applied to your account as long as any balance is due.
- Refunds are made only after your balance is completely satisfied with this office.
- If you receive any correspondence or checks from your insurance company, you must bring these into our office so that we may determine if any action needs to be taken.
- If you change insurance companies or employers, or choose to discontinue your insurance coverage you must provide this office with current information.

To ALL Patients:

You, the patient, are responsible for all collection fees, attorney fees, court costs, and interest on any balance over 60 days past due.

This office accepts Visa, Mastercard, Discover, Debit cards, cash, and personal checks as payment for services. A service charge of $ 15.00 will be assessed on all returned checks.

If you have any questions regarding this or any other matters, please speak with any office personnel.

I have read, understand, and agree to the above financial policy.

_____

Patient signature Date

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Summerville Chiropractic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I have the right to complain to the Practice or the US Secretary of Health and Human Services (as provided by the Privacy Rule) if I believe my privacy rights have been violated. All complaints must be in writing. To obtain more information about your privacy rights or if you have questions, you may contact this office's ***Privacy Officer: Donna Garland*** at (706) 857-4911 or 74 Highway 48 Summerville GA 30747.

I understand that Summerville Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Summerville Chiropractic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Summerville Chiropractic change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____ _____

Patient's Signature Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____.