

CONFIDENTIAL PATIENT HEALTH RECORD

Date: _____

PERSONAL HISTORY

Name: _____

Birth Date: _____ Age: _____

Address: _____

Sex: Male / Female

City _____ State: _____ Zip: _____

Home Phone: _____

Social Security #: _____

Cell Phone: _____

Driver's License #: _____

E-mail Address: _____

Business Employer: _____

Fax #: _____

Occupation: _____

Business Phone: _____

Name of Spouse: _____

Spouse's Employer: _____

Type of Work: _____

Names & Ages of Children: _____

Referred To This Office By: _____

Relationship: _____

Name & Number of Emergency Contact: _____

Who is Responsible for your bill, you and Spouse Worker's Comp Auto Insurance Medicare Medicaid

Personal Health Insurance Carrier: _____

Health Card ID #: _____

Insured Person's Name: _____

Group #: _____

Insured Person's Date of Birth: _____

Have You Had Previous Chiropractic Care? _____

Insured Person's Social Security #: _____

Name of Previous Chiropractor: _____

Amount of Time Under Care of a Chiropractor? _____

CURRENT HEALTH CONDITION

Chief Complaint (why you're here today) _____

PLEASE OUTLINE ON THE DIAGRAM THE AREA OF DISCOMFORT



When did this condition begin? _____

Has it ever occurred before? Yes No

Is condition: Auto Related Work Related Other No Injury

Explain: _____

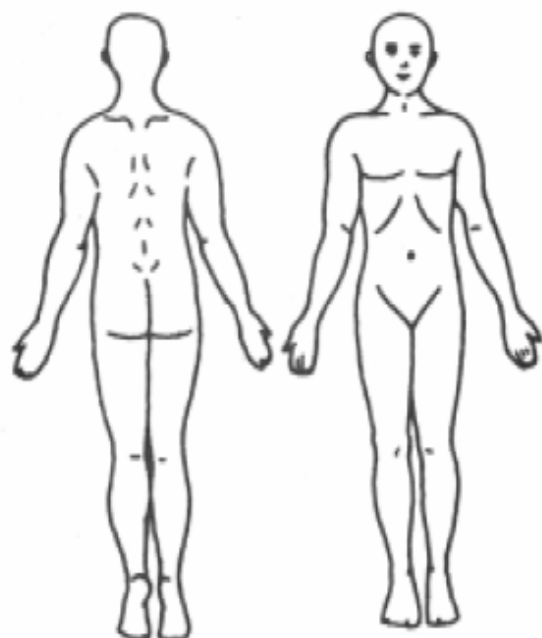
Date of Accident: _____

Time of Accident: _____

Complaint/Pain Onset Date: _____

If Work: Have you filed an injury report with your employer? Yes No

Claim #: _____



Patient Name: _____

Date: _____

CHIEF COMPLAINT – HPI FORM

MECHANISM OF ONSET:

1.) Before you began to suffer with this problem, was there an earlier accident, injury or condition that may or may not have been directly related to this problem? (Example: fall, auto injury, sports trauma, repetitive motion on the job.) _____

SYMPTOMS: When this problem is at it's worst, can you explain in your words how exactly it feels? Does it radiate? _____

QUALITY:

Burning Diffuse Dull/Aching Localized Sharp _____
 Shooting Stabbing Tingling Radiating Other

TIMING:

Worse AM Worse PM Worse w/ Activity Intermittent Constant Worse at Night

How often do you find yourself suffering from this problem? _____

How long does the problem last? (Get all the details of timing) _____

DAILY ACTIVITIES: Effects of Current Condition on Performance

Care - Family Member

Carrying Groceries No Effect Painful (can do) Painfull (limits) Unable to Perform

Change Positions -

Sit to Stand No Effect Painful (can do) Painfull (limits) Unable to Perform

Climbing Stairs No Effect Painful (can do) Painfull (limits) Unable to Perform

Pet Care No Effect Painful (can do) Painfull (limits) Unable to Perform

Driving No Effect Painful (can do) Painfull (limits) Unable to Perform

Extended Computer Use No Effect Painful (can do) Painfull (limits) Unable to Perform

Household Chores No Effect Painful (can do) Painfull (limits) Unable to Perform

Lifting Children No Effect Painful (can do) Painfull (limits) Unable to Perform

Reading/Concentration No Effect Painful (can do) Painfull (limits) Unable to Perform

Self Care - Bathing No Effect Painful (can do) Painfull (limits) Unable to Perform

Self Care - Dressing No Effect Painful (can do) Painfull (limits) Unable to Perform

Self Care - Shaving No Effect Painful (can do) Painfull (limits) Unable to Perform

Sexual Activities No Effect Painful (can do) Painfull (limits) Unable to Perform

Sleep No Effect Painful (can do) Painfull (limits) Unable to Perform

Static Sitting No Effect Painful (can do) Painfull (limits) Unable to Perform

Static Standing No Effect Painful (can do) Painfull (limits) Unable to Perform

Yardwork No Effect Painful (can do) Painfull (limits) Unable to Perform

Walking No Effect Painful (can do) Painfull (limits) Unable to Perform

MEDICATIONS: What medications are your currently taking, and for what conditions?

RECREATIONAL ACTIVITY:

_____ No Effect Painful (can do) Painful (limits) Unable to Perform
 _____ No Effect Painful (can do) Painful (limits) Unable to Perform
 _____ No Effect Painful (can do) Painful (limits) Unable to Perform

On a scale of 1 to 10, ten being the highest, rate your commitment to getting rid of the problem? _____

Concerns that could interfere with your commitment? (Time, Transportation, Other) Specify: _____

Policies

1. All examination, and 1st adjustment charges are payable when services are rendered. If the services are covered by your insurance policy, your account will be credited.
2. X-ray film is the property of this office. Once films are used for treatment purposes, they can be loaned upon the signature of a x ray release.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Back In Action Chiropractic Center will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Back In Action Chiropractic Center and will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered me are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount. I authorize Back In Action Chiropractic Center to obtain a credit report if deemed necessary.

Patient Signature _____ Date _____

Guardian Signature Authorizing Care _____ Date _____

In Case of Emergency Notify _____

Relationship _____ Address _____

Phone # _____

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to Back In Action Chiropractic Center, of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Back In Action Chiropractic.

Authorization To Release Medical Record Information:

Back In Action Chiropractic Center is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, Organizations, or agencies as may be responsible for payment of services rendered by Back In Action Chiropractic Center. This authorization I give with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Back In Action Chiropractic Center.

The undersigned certifies that He/She has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Signature of Witness: _____

Signature of Patient or Responsible Party: _____

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 a copy of our privacy notice, please understand that we have, and always will, respect the privacy of your health and personal 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 our 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.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. 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.

Your right to limit uses or disclosures

You may revoke any of your authorizations 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 your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

Printed Name Date

Authorized Provider Representative

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, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may interest 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 your 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 your claims.

Information that we use or disclose based on the authorization you are giving to 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 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 the authorization.

Patient name printed

Date

Patient signature

Authorized provider representative

Personal representative printed

Personal representative signature