

Patient Information & History

<div style="font-size: 2em; font-weight: bold; text-align: center;">1</div> <h3 style="text-align: center;">PATIENT INFORMATION</h3> <p>Name: _____ <small>(First) (Initial) (Last) (Name called by)</small></p> <p>Address: _____</p> <p>City, State, Zip: _____</p> <p>Birthday: _____ Age: ____ <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Social Security # _____/_____/_____</p> <p>Occupation: _____</p> <p>Employer: _____</p> <p>Parents Name(if a minor): _____</p> <p><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated</p> <p>Spouse's Name: _____</p> <p># of Children: ____ Name(s) _____</p>	<div style="font-size: 2em; font-weight: bold; text-align: center;">2</div> <h3 style="text-align: center;">INSURANCE</h3> <p>Who is responsible for this account? _____</p> <p>Relationship to patient _____</p> <p>Insurance company _____</p> <p>Insurance ID number _____</p> <p>Group / Claim number _____</p> <p>Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Insurance company _____</p> <p>Subscriber # and name _____</p> <p>Birthdate _____ Group # _____</p> <p>Please present insurance card(s) so we can put a copy in your file.</p>
<div style="font-size: 2em; font-weight: bold; text-align: center;">3</div> <h3 style="text-align: center;">ACCIDENT INFORMATION</h3> <p>Is your condition due to an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____</p> <p>Type of accident? <input type="checkbox"/> Automobile <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other</p> <p>To whom have you reported the accident?</p> <p>Insurance <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Employer <input type="checkbox"/> Other _____</p> <p>Attorney Name (If applicable) _____</p>	<div style="font-size: 2em; font-weight: bold; text-align: center;">4</div> <h3 style="text-align: center;">CONTACT INFORMATION</h3> <p>Home phone _____</p> <p>Cell phone _____</p> <p>Work Phone _____ Ext _____</p> <p>Email _____</p> <p>Best way to reach you <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Email</p> <p>IN CASE OF EMERGENCY, CONTACT</p> <p>Name _____ Relationship _____</p> <p>Home Phone _____ Cell _____</p>

5

PATIENT CONDITION

What is your major symptom/problem? _____

When did your symptoms begin? _____

Have you had this problem before? _____

Is your condition getting progressively worse? Yes No

Does your pain **radiate** from one area to another? If yes please explain:

Is this problem: constant comes and goes

How does it Feel? Burning Sharp Shooting Dull Aching Stiff
 Numb Tingling Throbbing Swelling Other _____

Circle below the severity of your pain on a scale of 0 to 10:
 (No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain) on average
 (No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain) at its worst

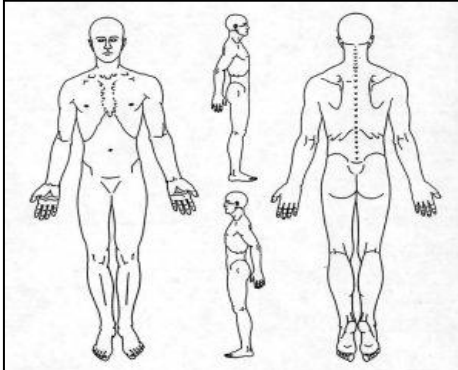
What makes your condition better? _____

What makes your condition worse? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities/movements that are painful to perform:
 Sitting Standing Walking Bending Lying down Driving Reading Getting Up

Please mark where it hurts



ACTIVE Chiropractic

Patient Information & History

6

HEALTH HISTORY

What other treatments have you had for this condition?

Chiropractic Orthopedic Neurologist Physical Therapy Medication Surgery

Name of other doctors who have treated you for this condition _____

Describe the other doctor's treatment for your condition _____

Previous Chiropractic care? No Yes Date _____ Local Out of state _____

Primary Care Physician _____ Phone: _____

Date of Last: Physical Exam _____ Spinal x-ray _____ MRI _____
 Spinal Exam _____ Dental x-ray _____ CT- Scan _____ Mark where you have pain/numbness

List any Medications you are taking _____

Vitamins / Herbs / Minerals _____

Females: Are you Pregnant Yes No Beginning of last menstrual cycle _____

Check any of the following conditions you have had:

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Headaches - Migraine | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Herniated disk | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sinus infection |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Irregular cycle | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Digestion problems | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Vertigo/Dizziness |

STRESSORS

Smoking _____ Packs/Day _____
 Alcohol _____ Drinks/Week _____
 Coffee/ Caffeine Drinks _____ Cups/Day _____
 High Stress Level _____ Reason _____

EXERCISE

None
 Moderate
 Daily
 Heavy

Have you had any:	Description	Date
Automobile accidents	_____	_____
Surgeries	_____	_____
Broken bones	_____	_____
Falls/Head injuries	_____	_____

7

AUTHORIZATION

Assignment of Benefits Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ (insurance company)
 I assign directly to Active Chiropractic Inc/Dr. Robert Green, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I also authorize release of medical information relevant to these services when required by Health Care Financing Administration (HCFA), its agents or insurance carriers for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Insurance Referrals

If you are required by your insurance to get a referral from your PCP before going to a specialist, you will need to have that referral in hand on the day of our first office visit. We will not be able to contact your PCP or Insurance to request one for you. Knowing your insurance benefits is your responsibility: Please contact your Insurance Company with any questions you may have regarding your coverage. Patients without the required referral will have to reschedule their appointments until it has been received in our office.

I have read and understand the above statements.

Print Name & Signature of Patient/ Guardian _____

Date _____



Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for the following purposes:
Treatment, payment, and health care options.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. This includes physical examination, scheduling other exams or appointments with other providers, physician-to-physician discussion for coordination of care and physician to staff discussion for coordination of care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a bill to your insurance company for payment.
- Health care operations include the business aspects of running our practice on a daily basis. The functions include, the entire staff having access to your file to obtain authorization of medical procedures, filing of paperwork, recording phone messages or vitals from your visit, confirming your appointment with our office, scheduling your appointment with our office and obtaining the medical complaint for your visit, and dictating notes to an outside source of your visit.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

We reserve the right to update these practices at any given time. You will then be required to review and resign acknowledging the changes and consenting to the changes.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are however not required to agree to a requested restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive and accounting of disclosures of protected health information.
- The right to receive a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.



This notice is effective as of June 1, 2008, and we are required to abide by the terms of the Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of the notice or the policies and procedures of this office.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer" at

Notice of Privacy Practices and Acknowledgement Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare Providers, who may be, involved in my treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time and that **I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.**

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand I may revoke this consent in writing at any time, except if you have taken action relying on this consent..

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____



Payment Policy

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.
 - a. **Referrals** – If your insurance requires a referral for a specialist, it is your responsibility to provide us with the referral dated the day of your first visit from your Primary Physician (PCP). We are not able to request a referral from your PCP or insurance on your behalf. If you do not have the referral at the time of your visit, your appointment will be rescheduled until we have the referral in our office
 - b. **Knowing your insurance benefits is your responsibility.** If you are unsure if you require a referral or have any other questions concerning your insurance, we suggest you contact your insurance company.
2. **Co-Payments and Deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud.
3. **Coverage Changes.** If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company denies your claim due to non-coverage or does not pay your claim within 60 days, the balance will be automatically billed to you.
4. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. **Missed Appointments.** Patients will be charged **\$35.00** for missed appointments not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges of our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of Responsible Party

Date