

CHIROPRACTIC PATIENT UPDATE

Please complete Parts A & C in all cases. Part B should be completed only if the information has changed since you were last in our office.

Thank You!

PART A

Name: _____ Phone: _____

E-mail address: _____ Fax # _____ Cell Phone _____

Address: _____

Purpose of this appointment: _____

Is this the same problem you were originally under care for? () Yes () No

If yes, are there any additional symptoms? _____

Other doctors seen for this condition: _____

What medications or drugs are you taking? _____

PART B

Occupation: _____ Employer: _____

Employer's address: _____ Work Phone: _____

Spouse: _____ Spouse's Employer: _____

PART C

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of **(16%)**.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Date Signed: _____ Signature: _____

Health Insurance Coverage () Yes () No

Company: _____

1. What is your major symptom? _____

2. If this is a recurrence, when was the first time you noticed this problem? _____
How did it originally occur? _____

Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

If yes, when and how? _____

3. How frequent is the condition? Constant _____ Daily _____ Intermittent _____ Night Only _____
How long does it last? All Day _____ Few Hours _____ Minutes _____

4. Are there any other conditions or symptoms that may be related to your major symptom?
Yes _____ No _____. If yes, describe _____

Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____

5. Describe the pain: Sharp _____ Dull _____ Numbness _____ Tingling _____ Aching _____
Burning _____ Stabbing _____ Other _____

6. Is there anything you can do to relieve the problem? Yes ___ No _____.
If yes, describe _____

If no, what have you tried to do that has not helped? _____

7. What makes the problem worse? Standing _____ Sitting _____ Lying _____ Bending _____
Lifting _____ Twisting _____ Other _____

8. Have you had any broken bones? Yes ___ No _____. If yes, please list and give dates _____

9. List any major accidents you have had other than those that might be mentioned above: _____

10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this
form either in the past or the present? Yes ___ No _____. If yes, please explain _____

11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
Yes _____ No _____ Uncertain _____

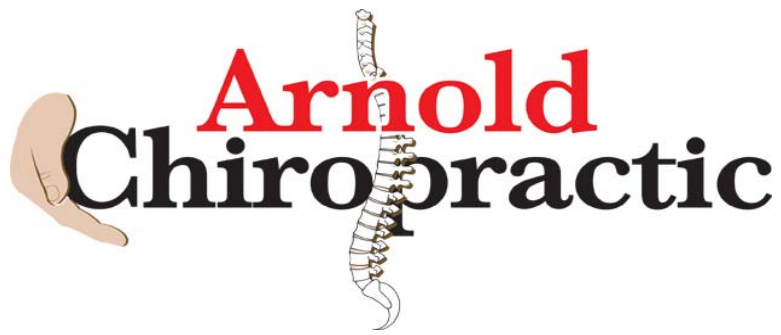
12. Remarks: _____

NO
SYMPTOMS

EXTREME
SYMPTOMS

Please place an "X" on the line above to indicate your level of problem.

Doctor's Signature _____ Date _____



RESCHEDULING, NO SHOW AND LATE CANCELLATION POLICY

YOUR APPOINTMENT IS TIME SET ASIDE ESPECIALLY FOR YOU. NO-SHOW APPOINTMENTS REPRESENT A COST TO US, TO YOU, AND TO OTHER PATIENTS WHO COULD HAVE BEEN SEEN IN THE TIME RESERVED FOR YOU.

IF YOU MUST CANCEL OR RESCHEDULE YOUR APPOINTMENT, PLEASE CALL OUR OFFICE TO INFORM US AT LEAST 4 HOURS PRIOR TO YOUR APPOINTMENT. PLEASE BE NOTIFIED THAT IF THE REQUIRED NOTICE IS NOT GIVEN, A \$50.00 FEE WILL BE CHARGED TO YOU AND IS IMMEDIATELY PAYABLE.

EXCESS ABUSE OF THIS POLICY WILL RESULT IN DISCHARGE FROM THIS PRACTICE.

Signature

Date