# 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: _____

Patient Name:_____ Date:_____ Patient Number:_____

## *Complaint History*

**Complaint 1:**

When did your complaint first begin? _____ or approximately _____ Weeks/Months/Years Ago
Have you ever experienced this complaint before? _____ When? _____
What makes the problem better? _____
What makes the problem worse? _____
Describe the type of pain/symptom you experience? _____
Does your problem travel into any other part of the body? ____ Where? _____
_____
Where exactly is the complaint area? _____
When do you notice the problem? _____
Have you lost control of any body part (arms, legs, bladder, bowel, etc…)? _____
Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? ____

**Complaint 2:**

When did your complaint first begin? _____ or approximately _____ Weeks/Months/Years Ago
Have you ever experienced this complaint before? _____ When? _____
What makes the problem better? _____
What makes the problem worse? _____
Describe the type of pain/symptom you experience? _____
Does your problem travel into any other part of the body? ____ Where? _____
_____
Where exactly is the complaint area? _____
When do you notice the problem? _____
Have you lost control of any body part (arms, legs, bladder, bowel, etc…)? _____
Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? ____

**Complaint 3:**

When did your complaint first begin? _____ or approximately _____ Weeks/Months/Years Ago
Have you ever experienced this complaint before? _____ When? _____
What makes the problem better? _____
What makes the problem worse? _____
Describe the type of pain/symptom you experience? _____
Does your problem travel into any other part of the body? ____ Where? _____
_____
Where exactly is the complaint area? _____
When do you notice the problem? _____
Have you lost control of any body part (arms, legs, bladder, bowel, etc…)? _____
Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? ____

Arnold Chiropractic

## 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.

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Signature Date

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