Patient Information

Date:_____ Patient #_____ **Doctor:**_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

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

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder
__Circulatory Problems	__Epilepsy	__Alcoholism
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction
__Seizures/Convulsions	__Strokes	__HIV Positive
__A Congenital Disease	__Cancer	__Gall Bladder
__Excessive Bleeding	__Ruptures	__Depression
__High/Low Blood Pressure	__Coughing Blood	__Ulcers

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? ☐ Yes ☐ No

If yes, describe:_____

Do you have any allergies of any kind? ❒ Yes ❒ No

If yes, describe:_____

Please list any other health problems you have, no matter how insignificant they may be:_____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?___ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Do you consume caffeine?____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting_____ sitting_____ bending_____working at a computer_____

FAMILY HISTORY:

Parents:
Father: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____ (check one)

Mother: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____ (check one)

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list:_____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis____
Diabetes ____
Stroke ____
Arthritis_____
Other _____

Cancer____
Asthma____
Kidney Disease____
Liver Disease ____

Mental Illness____
Heart Disease ____
Lung Disease____

Please check any and all insurance coverage that may be applicable in this case:
❒ Major Medical ❒ Worker's Compensation ❒ Medicaid ❒ Medicare ❒ Auto Accident
❒ Medical Savings Account & Flex Plans ❒ Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

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.

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.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Clinton Chiropractic Center
Office Policies & Procedures Agreement

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many Insurance plans, but we also have affordable options for patients without health insurance. Regardless of your coverage, we will suggest the chiropractic care we think you need to get you healthy and keep you healthy.

FINANCIAL ARRANGEMENTS AND POLICIEs

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services are rendered. If this office is billing my insurance for me, my portion would include any deductibles, copayments, or services not covered by my insurance. We do accept personal checks, however there is a $25.00 fee for all returned checks. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours' notice in order to reschedule your appointment.

INSURANCE BILLING/PAYMENT

I understand that I am ultimately fully responsible for products purchased and services provided by this office. This office is a participating provider with several insurance companies. For your convenience, this office will make an effort to verify your insurance benefits. However, ultimately it is the patient's responsibility to determine benefit and authorization information before services are rendered. Please note that verification of benefits is not a guarantee of payment. The insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of products and services not authorized or covered by their insurance company.

CASH PAYMENT POLICIES

This office requests that 100% of the first visit be paid at the time of the visit. We are happy to accept cash, check, Discover, AMEX, Master Card or Visa.

INFORMED CONSENT TO CHIROPRACTIC CARE

I request and consent to the performance of chiropractic examination, adjustment/manipulation and all other chiropractic procedures permitted by our state law, including medical records review, various modes of physiotherapy and necessary diagnostic X-Rays on myself (or on the patient named below, for whom I am legally responsible) by any of the treating Doctor of Chiropractic on staff and /or any licensed chiropractor deemed appropriate by the office. I understand that results of treatment are not guaranteed. I have been informed and I understand that in the practice of medicine, in this case chiropractic, there are risks associated with treatment, although rare, including, but not limited to , fracture, disc injuries, strokes, dislocations, strains, and worsening of symptoms, I do not expect the doctor to be able to anticipate and explain all risks and complications of my case, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based on the facts the known, and is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

In accordance with all stated above, I hereby understand and agree to the above stated office policies.

Patient's Name (Print) _____

Signature: _____ Date:___/____/_____

(Patient, Parent or Legal Guardian)

Clinton Chiropractic Center, LLC
119 N. 9th Street
Clinton, OK 73601
(580) 323-4250

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Regarding the Use & Disclosure of Protected Health Information

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

By signing below I acknowledge that I have read and received a copy (if chosen) of ***Clinton Chiropractic Center, LLC*** *Notice of Privacy Practices.*

Patient Name: _____

Signature of patient or personal representative: _____

If not patient signature, relationship of representative: _____

The following person(s) is allowed to request my personal health records on my behalf:

_____

Signature of patient/personal representative: _____

Today's date and therefore effective date of this agreement is this date: _____/_____/_____
Expiration date: December 31, _____

Office Use Only:

Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient name: _____ Refused to sign ☐ Physically unable to sign ☐

(Other) _____

_____

Employee Signature: _____ Date: _____