CHIROPRAC IC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ 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.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

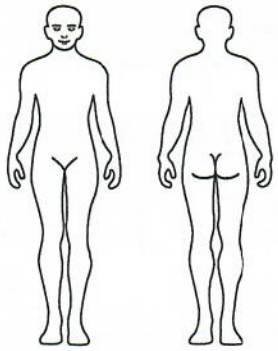
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

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

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name _____		
Pharmacy Phone (____) _____		

VERSAILLES CHIROPRACTIC – DR. SCOTT M. GLADDIS, DC
260 Crossfield Drive, Versailles, KY 40383 • Phone: 859-879-0024; Fax: 859-879-1102

Advance Benefits Notice to All Patients

(1) COPAYMENTS, COINSURANCE & DEDUCTIBLES
All patients with the following: copayments, coinsurance amounts or deductibles must pay charges at the time of service (subject to our "estimating charges" policy below). This policy exists because of increasing issues with non-payment of accounts. **Copayments are to be collected at the time of service *as required by contractual agreements with insurance companies* and the Federal HIPPA Law that governs patient privacy and medical insurance coverage and benefits.** If you have two commercial insurances (not Medicare or Medicaid), we are required to collect a copayment (usually from the primary insurance). Do not assume that multiple insurance policies forgive your requirement to pay.

(2) PATIENTS WITH MEDICARE & MEDICARE REPLACEMENT POLICIES
If you have Medicare, we are required by the Centers for Medicare and Medicaid Services to have you complete an Advanced Beneficiary Notice (ABN). This is a separate form issued by the Centers for Medicare and Medicaid Services. Medicare patients must complete this form that discloses charges and possible charges that this office may bill a Medicare patient, including a one-time fee of $40.00 for an examination (not covered by Medicare). If you have a Medicare Replacement Policy, this is your notice that you: (1) will not have to complete the separate Medicare ABN form as this notice takes the place of the Medicare ABN, (2) you will be subject to paying the initial visit (one time) $40 examination fee, and (3) you may have to pay for charges not allowed by the Medicare Replacement Policy if billed or purchased (includes: services, Items, or equipment you may opt to buy or order).

(3) A PATIENT'S RESPONSIBILITY
Patients have a responsibility to understand their insurance policy and to know their copayment amount, their deductible, out-of-pocket limits, coinsurance responsibility, and number of visits allowed by insurance. If your insurance does not pay, you will be billed for unpaid balances, and you will be expected to pay balances promptly upon receipt of a Statement of Account from Versailles Chiropractic. **Some services are not covered by insurance. You may be expected to pay for non-covered services either at the billed amount or an amount discounted by Versailles Chiropractic**. You, your employer, or plan sponsor selects the plan and the type and scope of coverage you have. If you have concerns about your insurance, you should contact your plan sponsor or your insurance company.

(4) KNOW YOUR INSURANCE BENEFITS
We are providers of health care. We are not insurance companies. There are hundreds of various plans. We cannot know all plans offered by all insurance companies. Do not expect staff to know the specifics of your plan. Staff obtain plan information when you present your insurance card by either phoning your insurance company or by obtaining benefits from an insurance web portal. We do not guarantee the information provided is accurate, and you should know that the information we obtain is sometimes incorrect. When we ask for copayments, coinsurance or deductible payments, we are following the guidelines of your insurance plan. While most insurance plans cover chiropractic, you should know that benefits for chiropractic care *may differ from benefits provided by a medical doctor.* Chiropractors are "specialists."

(5) OUR SERVICE TO YOU & ESTIMATING CHARGES
Our office staff *will attempt* to contact your insurance provider when you register. *We are not required to do this. We do not guarantee the information to be correct.* **THE AMOUNT WE WILL COLLECT FROM YOU IS AN ESTIMATE.** If your insurance misquotes, has bad or unclear information posted to the web portal, or we make an error, you are still responsible for any balance due. We will send a Statement of Account, and payment is expected upon receipt of a statement from this office. We will follow the insurance company's remittance advice that advises us of your financial responsibility and the insurance company's responsibility. If you owe amounts for any reason, including, but not limited to: (1) incorrect insurance card/information, (2) incorrect information provided by the insurance company, (3) non-covered services, or (4) a doctor's office error, you will be responsible for paying the account balance. *Errors do not forgive your financial obligation.* If you owe Versailles Chiropractic, we will send you a bill for the balance due. If you overpay Versailles Chiropractic, we will hold your balance on account unless you specifically request a refund. We hold money on account because insurance companies make errors and often recoup (ask for a refund from Versailles Chiropractic) money from us, making the patient responsible in many cases.

Please sign and date below. If you have questions about this information, please ask staff to explain.

I have read the above information:

Patient's Signature:_____ Date:_____

VERSAILLES

CHIROPRACTIC
260 Crossfield Drive Unit 2
Versailles, KY 40383
Phone: 859-879-0024 Fax: 859-879-1102

Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____

Date of Birth: _____/_____/_____
(month) (day) (year)

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides me with the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my protected health information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I may obtain this practice's current Notice of Privacy upon written request.

Signature:_____

Date:_____

Relationship to patient (if signed by a personal representative of patient):

_____

VERSAILLES
CHIROPRACTIC
Dr. Scott Gladdis, D.C.
260 Crossfield Drive Unit 2 • Versailles, KY 40383
Phone: 859-879-0024 Fax: 859-879-1102

(Effective Date: 4/1/03)

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.

We care about our patient's privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of your protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the Privacy Officer at this practice.

Who Will Follow this Notice
Any health care professional authorized to enter information into the patient record, employees, staff and other personnel at this practice who may need access to your information must abide by this notice. All subsidiary business associates (e.g., a billing service), sites and locations of practice may share medical information with each other for treatment, payment purposes or health care reasons as described in this notice; when treatment is involved, only the minimum necessary information needed to accomplish the task will be released.

How We May Use and Disclose Medical Information about You
The following categories describe different ways that we may disclose medical information without specific consent or authorization, examples are provided; not every possible use or disclosure has a category listed.

For Treatment
We may use or disclose your health information to a physician or other health care provider providing treatment to you.

For Payment
We may use and disclose your health information to obtain payment for service we provide to you.

For Health Care Operations
We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures that Can be Made without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other health care providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' health care operations activities (to the extent permitted under HIPAA)
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

(over)

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also contact you in the form of a newsletter, etc.

Uses and Disclosures of Protected Health Information
Requiring Your Written Authorization
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services (Address: 200 Independence Ave., S.W., Washington, D.C. 20201; Telephone: 202-619-0257 or 877-696-6775). All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will abide by your request unless the information is needed to provide you with emergency treatment. To request a restriction, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation as to how payments will be handled under the alternative means or location you request.

Right to Inspect. You have the right to inspect and request a copy of your medical records.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. You must provide a written copy of the request and a reason that supports your request. Records received from other facilities cannot be changed in this office. A request must be submitted to that facility in writing.

Right to an Accounting of Non-Standard Disclosures. You have the right to request (in writing) a list of the disclosures we made of medical information about you. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years and may not include dates before April 14, 2003.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice at any time.

Changes to this Notice. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current notice, with the effective date in the upper right corner of the first page.