

Brandon Hanes, DC
Abby Palmer, DC



Julie Proctor, PTA
Cassie McHenry, MPT

CHIROPRACTIC PHYSICAL THERAPY NUTRITION

Patient's Name: _____	Chief Complaint: _____
Address: _____	Home Phone: _____
City: _____ Zip: _____	Cell Phone: _____
SS#: _____	Email: _____
Date of Birth: _____	Marital Status: M S W D
Occupation: _____	Employer: _____
Address of Insured (if different than above): _____	
Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment)? _____ Yes _____ No	

Ins Company: _____	Ins. Phone #: _____
ID#: _____	Group #: _____
Name of Policy Holder: _____	Policy Holder DOB: _____
Policy Holder's Employer: _____	

Family Physician: _____ (Note: May we send your health information to this provider? Y/N)

Person to contact in case of emergency (Name & Phone): _____

Have you ever been under Chiropractic Care? Y / N If so, Who? _____

Have you had any SPINAL X-rays/ MRI's / CT's taken in the last year? Y / N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pacemaker? Y / N Have you ever had any Hip or Knee Replacements Y / N

What medications are you taking? (Check those that apply) Pain Killers _____ Insulin _____ Cholesterol Meds _____
Blood Pressure Meds _____ Muscle Relaxers _____ Birth Control _____ Other: _____

What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Hanes Total Healthcare Center all medical benefits and or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and or employee health care plan any claim, chose in action, or other right I may have to such insurance and or employee health care benefits coverage under any applicable insurance policies and or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for your cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and or employee health care plan in my name but at such doctor and clinic's expenses.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/ Guardian: _____ Date: _____

Name: _____

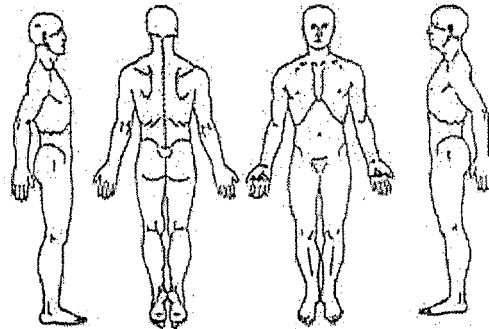
1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of Pain (% of the week you experience the pain).

Condition / Problem	Severity										Frequency (% of week)											
	Minimal					Severe					Occasional					Constant						
a. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
b. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
c. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
d. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
e. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100

(Please mark the figures where you experience pain.)

2. Symptoms are worse in the (circle what applies)

Morning Increase during the Day
Afternoon Same all Day
Night Decrease during the Day



3. Symptom (a) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

4. Symptom (b) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

5. When did your symptoms begin (onset date)? _____

6. How did your symptoms begin? _____

7. Have you experienced these before? _____

8. Do your symptoms radiate? _____

9. Has your condition? _____ Improved _____ Gotten Worse _____ Stayed the same since it began

10. Circle the things that make your problems worse:

Bending Laying Walking Standing Sitting Movement Twisting Lifting Sleeping

11. Is there anything you can do to relieve the problems? Yes / No If yes, Describe? _____

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

12. Have you been treated for this before? Yes / No If yes, how long ago? _____

13. What treatment did you receive? _____

14. Results of previous treatment? Good or Poor Comments? _____

15. Were you referred to our office by anyone? _____

16. Is this condition interfering with: Work Sleep Daily Routine Recreation

17. List any other major injuries you have had, other than those mentioned above: _____

18. Any other musculoskeletal problems? Yes / No or Neurological Problems? Yes / No

Additional Information: _____

I certify that the above information is accurate to the best of my knowledge.

Patient/ Guardian Signature _____ Date: _____

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CHIROPRACTIC PHYSICAL THERAPY NUTRITION

Patient Name: _____

Date: _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read below and if you have any questions please feel free to ask one of our staff members.

Informed Consent

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Hanes Total Healthcare Center**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained upon request.

Women Only

To the best of my knowledge to xray me for diagnostic interpretation (circle one of each):

I am pregnant or I am not pregnant

I give my permission or I don't give my permission

Consent to Evaluate and Treat a Minor

I _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: _____

May we leave messages regarding your personal healthcare information on any answering device,
i.e. home answering machines or voicemails? Yes / No

Acknowledgment

I have read and fully understand the above statements. I have reviewed the notice of privacy (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____

Date: _____

Protecting Your Health Information

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPAA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect or domestic violence of the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with the laws relating to worker's compensation, auto accidents, personal injury or other similar issues.

If someone calls or comes by, they will not be given any information about your care and or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and or picture in our lobby unless otherwise specified. Upon becoming a patient, we will be entering your name and email into our database. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Notification by Mail or Phone

Patient's may be contacted by mail, email, or phone unless written notification is requested that contact be only in person.

Complaints

If you feel your rights have been violated, contact the office manager or the U.S. Department of Health and Human Services.

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Patient Waiver to Assume Financial Responsibility

I am signing this waiver acknowledging that I understand my insurance coverage and limits for services rendered. My insurance benefits are not a guarantee of payment. I understand it is my responsibility to provide this office with accurate insurance information and I can call my insurance company at any time with questions about my policy. Hanes Total Healthcare Center is agreeing to bill my insurance for services rendered however, I am financially responsible for services not covered under my particular policy/plan. Such services may include but are not limited to:

- *Exams
- *X-rays
- *Manual Traction
- *Intersegmental Traction
- *Extremity adjustment
- *Ultrasound
- *E-Stub (EMS)

Your signature below indicates that you received the explanation and notification of your financial responsibility. I am signing this waiver acknowledging that I understand my insurance coverage and limits for services rendered. I am agreeing to be put on a cash account and take financial responsibility for my services after my insurance benefits have been reached and/or for services performed under the standard of care but not covered by my insurance.

Printed Name of Patient

Date

Signature of Patient (Parent/Guardian if under 18)

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Cancellation Policy: Effective September 1, 2023

Due to the high volume of same day cancellations and no shows, our office will now have a cancellation fee for the following services:

- Physical Therapy: \$30.00
- Dry Needling: \$30.00
- Stretch Therapy: \$30.00
- Personal Training: \$30.00

All of our doctors and therapists appreciate the opportunities to deliver the highest quality of care possible. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. In 2022, our office had over 10,000 cancellations and no-show appointments while still paying our therapists. If you no-show or an appointment is not canceled at least 24 hours in advance, you will be charged a \$30.00 fee which is not covered by your insurance.

Our email and text messaging reminder system is a courtesy to patients only, but patients are responsible to keep or cancel their appointment regardless of whether they receive a reminder or not. Not receiving an electronic notification of your appointments from Hanes Total Healthcare is not sufficient reason to miss an appointment.

If you are uncertain when your next appointment with our office is, please contact us to confirm.

I have read, understand and agree to the above.

Patient Name: _____

Patient/Guardian Signature: _____

Date Signed: _____

WWW.HANESHEALTH.COM

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