Brandon Hanes, DC
Abby Palmer, DC

Brien Polivka, DC
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 herby 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.

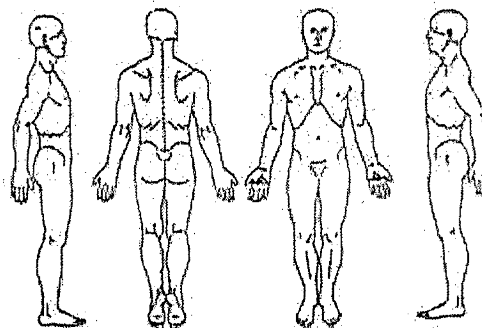
Signature of Insured/ Guardian: ______________________ Date: ______________

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 (Minimal – Severe)	Frequency (% of week) (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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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. I am agreeing to be put on a cash account and take financial responsibility for my services after my insurance benefits have been reached.

____
Patient's Printed Name

____
Signature of Insured / Guardian

____
Date

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