Fletcher Chiropractic - Confidential Patient Information

Last, First Name	DOB	Age	Sex	Marital Status

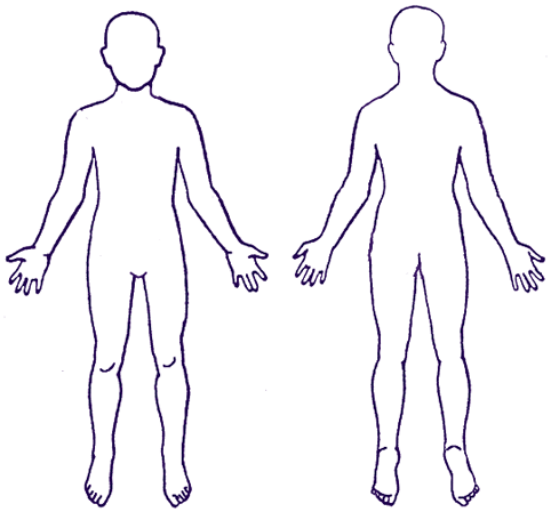
Address	City	State	Zip Code

( ) Home phone	( ) Cell Phone	Cell phone carrier	Text msg reminder yes or no	E-mail Address

Social Sec#	Occupation	Company Name/Location	Phone#

Guardian/Spouse's name	Guardian/spouse's DOB	Guardian/spouse's SS#	Guardian/spouse's employer

On the diagram to the right mark with an X where you are experiencing symptoms.



Your present complaint(s) _____

_____

_____

_____

_____

_____

Who referred you to/ how did you hear about our office?

_____

Will this be a part of a claim for: Personal injury_____ or worker's comp claim _____?

Emergency Contact: _____ **Relationship:** _____ **Phone: (___)**_____

List other doctor(s) seen for this condition _____

Have you ever had chiropractic care? Yes_____ No_____ Date of last adjustment_____

Have you ever had massage therapy? Yes_____ No_____ Date of last massage_____

List any operations you've had and the dates: _____

Have you been treated by a physician for any health conditions in the last year? Yes_____ No_____

Describe condition _____ **Date of last physical exam** _____

Are you now taking any medication? Yes_____ No_____ List: _____

Are you pregnant? Yes_____ No_____ Date of last menstrual period _____

Do you have insurance? Yes_____ No_____ Company _____

Primary Care Physician_____ **Location**_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in 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. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Fletcher Chiropractic extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Fletcher Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary. I certify that the above information is true and correct.

Patient's (Guardian's) Signature _____

Instructions: Please carefully consider and answer each question as completely as possible.

Name:_____ Today's Date: (____/____/____) Date of Accident:(____/____/____)

If this was an auto accident, were you the: Driver_____Passenger_____Pedestrian_____

If auto collision, were you struck from: Behind_____Right_____Left_____Front_____Auto was parked_____
other _____

Did your car strike the other(s) involved? Yes No. Did the other car strike yours? Yes_____ No_____

Were traffic tickets issued? Yes___No__ If "**yes**," to whom: You____the other driver____ the driver of your car___

Did any part of your body strike any part of the car? Yes____No____. If "**yes**," please explain: _____
_____

Did you have a safety belt on? Yes_____ No_____. Shoulder strap? Yes_____No_____.

Does your car have a headrest? Yes___No___. Height or position? Shoulder___Neck____Head_____Above_____.

Did you lose consciousness? Yes_____No_____. If "**yes**," please explain:_____
_____

Were you stunned? Yes_____No_____. If "**yes**," how long? _____

Did you feel or hear a popping, tearing, or a ripping noise in your neck or back? Yes_____No_____. If "**yes**," please explain:_____

Did you feel any pain? Yes____No____. If "**yes**," where? _____

How long after the accident did you feel pain? _____

Did you notice any bruising? Yes____No____. If "**yes**," where? _____

Did you require post-accident care or hospitalization? Yes____No____. If "**yes**," where? _____

Were you examined by a healthcare professional? If "**yes**," by whom? _____

Were you x-rayed? Yes____No____. Was any treatment given? (medication, supports, braces, or recommendations):

What is your occupation? _____ What duties are required of you on the job?_____
_____

Have you missed work as a result of this accident? Yes____No____. If "**yes**," how many days? _____

Insurance Companies

YOUR Auto Ins Co_____ Ins. Adjustor Name:_____
Address _____ City_____ State_____Phone_____
Insurance of responsible party? _____Ins. Adjustor Name:_____
Address _____ City_____ State_____Phone_____

Your Attorney

Name of Firm:_____ Attorney Name:_____
Address _____ City_____ State_____Phone_____

PLEASE CHECK ALL SYMPTOMS YOU HAVE HAD SINCE THE ACCIDENT:

☐	Headache	☐	Low Back Pain	☐	Face Flushed	☐	Constipation
☐	Skull or Head Pain	☐	Low Back Stiffness	☐	Loss of color, pale	☐	Excessive Perspiration
☐	Neck Pain	☐	Hip Pain	☐	Dizziness	☐	Loss of Perspiration
☐	Neck Stiffness	☐	Buttock Pain	☐	Fainting	☐	Loss of Taste
☐	Head feels too heavy	☐	Leg Pain (Rt/Lt)	☐	Sinus Trouble	☐	Cold Sweats
☐	Shoulder Pain	☐	Leg Numbness	☐	Loss of smell	☐	Fever
☐	Shoulder Stiffness	☐	Pins and Needles in Legs	☐	Eye Strain	☐	Swelling in_____
☐	Arm Pain (Rt/Lt)	☐	Numbness in Feet/Toes	☐	Difficulty Focusing	☐	Heart Palpitations
☐	Arm Numbness	☐	Cold Feet	☐	Pain behind eyes	☐	Depression
☐	Pins/Needles in Arms	☐	Loss of Circulation	☐	Numbness in Hands	☐	Anxiety
☐	Cold Hands	☐	Excessive Sleep	☐	Eyes Sensitive to Light	☐	Double Vison
☐	Upper Back Pain	☐	Irritability	☐	Difficulty Sleeping	☐	Tension
☐	Upper Back Stiffness	☐	Nervousness	☐	Digestive Problems	☐	Tremors
☐	Mid Back Pain	☐	Mental Dullness	☐	Loss of Balance	☐	Diarrhea
☐	Mid Back Stiffness	☐	Loss of Memory	☐	Nausea	☐	Painful Breathing
☐	Pain doing occupation	☐	Difficulty Rising	☐	Vomiting	☐	Fatigue
☐	Ringing in Ears	☐	Shortness of Breath	☐	Chest Pain	☐	Rib Pain

NECK

The **PAIN** is:	The **SEVERITY** is:	The **QUALITY** is:	The **PAIN** is greater:
____Constant	____Mild	____Dull	____on the left side
____Intermittent	____Moderate	____Sharp	____on the right side
____Occasional	____Severe	____Stabbing	____equal on both sides

Other_____

MID BACK

The **PAIN** is:	The **SEVERITY** is:	The **QUALITY** is:	The **PAIN** is greater:
____Constant	____Mild	____Dull	____on the left side
____Intermittent	____Moderate	____Sharp	____on the right side
____Occasional	____Severe	____Stabbing	____equal on both sides

Other_____

LOW BACK

The **PAIN** is:	The **SEVERITY** is:	The **QUALITY** is:	The **PAIN** is greater:
____Constant	____Mild	____Dull	____on the left side
____Intermittent	____Moderate	____Sharp	____on the right side
____Occasional	____Severe	____Stabbing	____equal on both sides

Other_____

OTHER Please explain the location of the pain (i.e. right forearm, left calf)

The **PAIN** is:	The **SEVERITY** is:	The **QUALITY** is:	The **PAIN** is greater:
____Constant	____Mild	____Dull	____on the left side
____Intermittent	____Moderate	____Sharp	____on the right side
____Occasional	____Severe	____Stabbing	____equal on both sides

Other_____

WHAT CAUSES YOU DIFFICULTY: Please check as many as necessary.

____STANDING ____SITTING ____LYING DOWN ____OTHER_____

WALKING:	RIDING: (in auto)	BENDING:	TWIST/TURN:	LIFTING:
____Minimal	____Minimal	____Minimal	____Minimal	____Light
____Moderate	____Moderate	____Moderate	____Moderate	____Medium
____Extended	____Extended	____Extended	____Extended	____Heavy
			____Repetitive	____Repetitive

_____Rise to walk

_____Cough or sneeze

DOES THE PAIN RADIATE INTO YOUR: Please check as many as necessary.

SHOULDER(S)	ARM(S)	HIP(S)	LEG(S)
____left	____left	____left	____left
____right	____right	____right	____right
____both	____both	____both	____both

____other: Pain radiates into my_____

IS WORSE:
____in the a.m.
____in the p.m.
____following:
____routine activity _____
____moderate activity_____

INTERFERES with:
____work
____sleep
____other_____

Date of Accident:_____ Time:_____ (am/pm) Weather:_____ Road Conditions_____

Street(s):_____

Street(s):_____

Patient Headed (N S E W)

Patient Speed:_____Mph

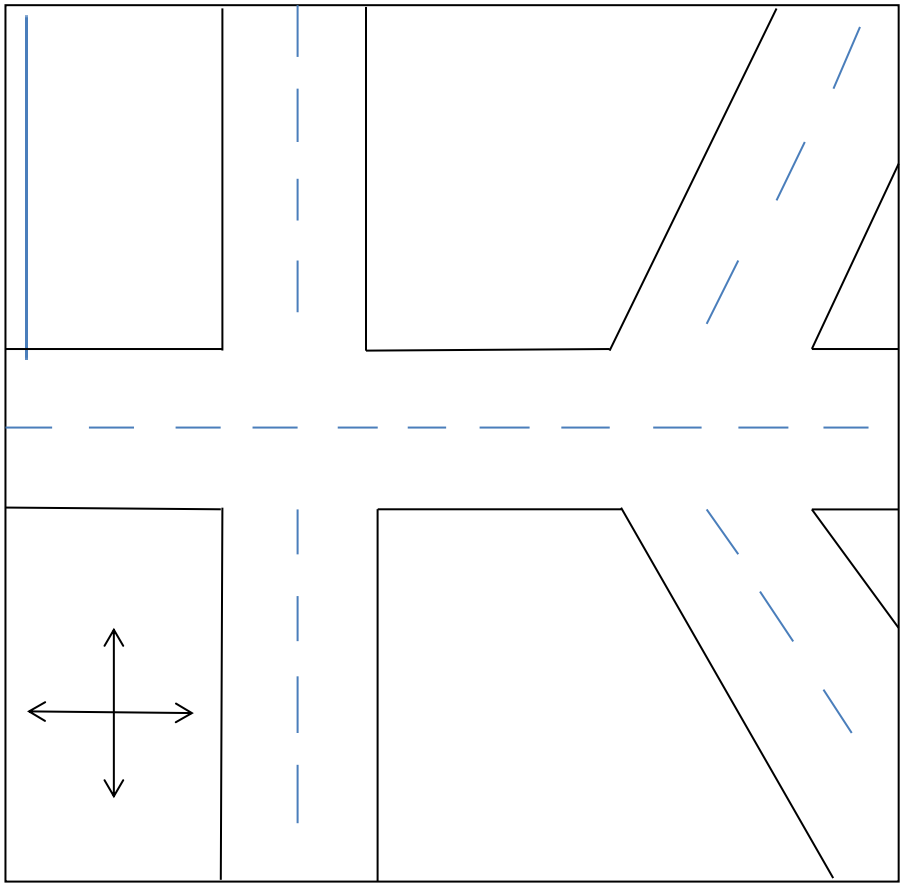
Patient Car Type:_____

Patient Car Hit:_____

Other(s) Headed (N S E W)

Other(s) Speed:_____Mph

Other(s) Car Type:_____



IMPACT

Body: (Straight / Bent / Twisted) (Left / Right) Miscellaneous: _____

Head: (Neutral / Up / Down) (RT / LT) _____

Braking: (On / Off) _____

Patient Awareness: (None / Partial / Very) _____

The following is an explanation of our office policies. We believe that a clear understanding will allow us both to concentrate on the most important issues; regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account or insurance coverage.

Complimentary Consultation

Fletcher Chiropractic will conduct a special "no charge" consultation, or brief conference, with anyone interested in finding out if chiropractic can help them with their individual health problem. There is no charge or obligation in connection with this appointment**.**

Patient Payment Policy

We feel the patient's health needs are paramount. Therefore, the following Patient Care Services policy is an attempt to allow you, the patient, to receive the care you need and clear your balance with the least amount of difficulty.

Patient Care Services

Payment in full for all services is due at the time of service unless other arrangements have been made. Payment arrangements may be made with the office and payments must be made no less than monthly. Please understand that all services rendered to you are charged directly to you and you are responsible for payment, regardless of your insurance coverage. Properly documented Worker's Compensation and auto accident claims are not required to pay at the time of service if appropriate forms and liens are signed.

Our Policy on Health Insurance

Many insurance policies cover chiropractic care. We will be happy to file your insurance claim for you and do everything we can to ensure you receive reimbursement. However, we cannot take responsibility for what your health insurance will or will not cover. It is important that you understand that health and accident insurance policies are an arrangement between an insurance carrier and you the patient, their insured. Of course, Fletcher Chiropractic will prepare any necessary reports and forms to assist you in collecting from your insurance company. Furthermore, any amount authorized to be paid directly to Fletcher Chiropractic will be credited to your account upon receipt.

Massage Therapy Appointments

In order to better serve our patients we ask that you call if you are unable to make your appointment or if you are running late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. Please help us help others. Our office has a $60.00 no show/late cancellation charge if we fail to receive 24 hours notice. Please call our office as soon as possible if you are not going to make your scheduled appointment.

Identification Policy

Fletcher Chiropractic requires a copy of photo identification (ex: driver's license, passport, student ID) be on file in order to receive care.

Questions and Answers

Your questions about any aspect of your care or account are invited. Please feel free to ask the Doctor or any available staff member. We will make every effort to answer and address your concerns.

I have read the Fletcher Chiropractic clinic policies and agree to honor them:

Print:	**Sign:**
Date:	

NOTICE OF LIKELIHOOD OF INSURANCE DENIAL OF BENEFITS

I understand that my insurance company may deny payment for the service provided to you for the following reasons:

That the particular service is not reasonable and/or necessary under my insurance company's standards or considered experimental.

For this reason, please read and sign the following statement:
"I have been informed by my physician that he believes that, my particular case, my insurance may deny payment for the services identified above, for the reasons stated. If my insurance denies payment I agree to be personally responsible for payment of said services.

Print:	**Sign:**
Date:	

ASSUMPTION OF FINANCIAL RESPONSIBILITY

****Explanation of benefits disclaimer****

I, the undersigned patient, completely understand that Fletcher Chiropractic provides insurance billing and insurance benefit verification as a courtesy to their patients. I understand that the service Fletcher Chiropractic provides for verification of insurance coverage is in no way a promise of payment by my insurance company. If my insurance company denies my claim(s) for any reason, or misquotes my benefits to Fletcher Chiropractic, the balance of my account will be billed to me and due to the clinic.

It is the policy of Fletcher Chiropractic to never enter into a dispute with your insurance company for any reason.

I, the undersigned patient, completely understand the insurance services provided to me regarding my insurance coverage as stated above. I understand that my signature below serves as a "signature on file" to bill the above insurance company and allows this clinic to accept assignment of insurance benefits. I understand the above "Benefits Disclaimer" and my financial responsibilities to any services rendered by this clinic. I understand that Fletcher Chiropractic, PS may have a contract with my insurance company that allows only co-pays to be collected at time of service. By signing this form, I am agreeing to pay any co-pay, deductible and coinsurance at time of service. This may offer a reduced fee for paying at the time of service rendered.

Print:	**Sign:**
Date:	

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Fletcher Chiropractic.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledgement receipt of the Notice of Privacy Practices

_____

Patient or legally authorized individual signature Date Time

_____

Printed name if signed on behalf of patient Relationship

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

Additional Disclosure Authority

In addition to the allowable disclosures describe in the "Notice of Privacy Practices", I hereby specifically authorize disclosure of my protected health care information to the person indicated below.

Any member of my immediate family: Yes_____ No_____
Spouse Only: Yes_____No_____
Other: (Please Specify) Yes_____ No_____
My Designated Primary Care Provider: Yes_____No_____*Re-evaluation findings only.

Signature: _____ Date:_____

FLETCHER CHIROPRACTIC CENTER
SCOTT FLETCHER, D.C.

Personal Medical Information Consent Form

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive payment and/or as part of health care operations of our practice.

HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

HIPAA gives the patient a right to add restrictions to the release of Protected Health Information. We as an office do not have to agree to these restrictions. But if we do they are legally binding.

You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

Patient Signature_____Date_____

Restrictions: