CARBONDALE CHIROPRACTIC INJURY Clinic

WELCOME

Office Use Only:

Account #-

CC-

1 About You

Today's Date____/____/_____

Patient's Name_____

Preferred Name_____

SSN_____-____-_____ Male Female

Age _____ Birthdate ____/_____/_____

Address_____

City_____ State____ Zip_____

Email _____

Phone_____

Work Phone_____

Referred By_____

Employer_____ How Long ____

Employer's Address_____

Occupation_____

Status- Minor Married Divorced Separated Widowed Single

Spouse's Name_____

Children? _____ How Many? _____

2 Account Info

Person ultimately responsible for account

Name_____

Relation_____

Billing Address _____

_____

SSN ___ __ ____ License #_____

Phone # ___ ___ ____

Payment Method _____

_____ (Initials) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

3 Insurance Info

Primary Insurance

Co. Name_____
Address_____
_____
Phone #_____
Insured's Name _____
Insured's SSN_____ DOB __/___/____
Relation _____

Secondary Insurance

Co. Name _____
Address _____
_____
Phone #_____
Insured's SSN___ __ ___ DOB __/__/____
Insured's Name _____
Relation _____

4 In Event of Emergency

Who should we contact? _____
Relation_____
Mobile Phone ___ ___ ____
Work Phone ___ ___ ____
Who is your medical doctor? _____
M.D's Phone # _____-____

5 Reason for Visit

Reason for today's visit (circle): Emergency New Injury Old Injury Chronic Pain Wellness

Are you in pain? YES NO Rate your pain on a scale from 1 to 10 (1= no discomfort/ 10 intense) _____

Did your injury occur during (circle) Work Sports/Play Auto Accident Routine/Household Activity

When did your condition/accident occur? __/__/__ Where did your injury occur? _____

Please explain what happened _____

Is your condition getting worse? YES NO If yes, explain _____

Has this or something similar happened in the past? YES NO If yes, explain _____

Have your been treated by a Medical Physician for this condition? YES NO If yes, where _____

Have you been treated by a Chiropractor? YES NO Clinic Name/ Phone _____

6 Health History

What medications are you currently taking? (Please include over the counter) _____
_____ Dosage? _____

Do you have any of the following diseases, medical conditions or procedures? (Check all that apply)

__Heart Murmurs	__Heart Surg/Pacemaker	__ Heart Attack/ Stroke	__Cong. Heart Defect	__ Mitral Valve Prolapse
__ Artificial Valves	__ Alcohol/Drug Use	__ Venereal Disease	__Fainting/Seizures/Epilepsy	__ HIV+/AIDS/ARC
__ Shingles	__ High/Low Blood Pressure	__ Frequent Neck Pain	__ Difficulty Breathing	__ Anemia/ Diabetes
__ Cancer	__ Psychiatric Problems	__Rheumatic Fever	__Severe/ Frequent Headaches	__ Kidney Problems
__ Ulcers/Colitis	__ Hepatitis	__ Sinus Problems	__ Emphysema/ Asthma	__ Tuberculosis
__ Glaucoma	__ Chemotherapy	__ Lower Back Problems	__ Artificial Bones/Joints/Implants	__ Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above _____

_____

List any past accidents with dates_____

Please list anything you may be allergic to _____

Family Health History _____

Do you smoke? YES NO How Much/ How Long? _____ Do you take Supplements or Vitamins? YES NO

Are you wearing (circle) Shoe Lifts Inner Soles Arch Supports

Are your dieting? YES NO Exercising? YES NO ____hours per week

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have made with the office manager. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred on collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/_____
(Circle) Adult Patient Parent/Guardian Spouse

CARBONDALE CHIROPRACTIC INJURY Clinic

Authorization

I certify that I have read and understand the information to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Align Chiropractic LLC (DBA Carbondale Chiropractic Injury Clinic), to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to a third party and/or health practitioners. I authorize and request my insurance company to pay directly to Align Chiropractic (DBA Carbondale Chiropractic Injury Clinic), and insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of me or my dependents.

X _____

Signature of patient (or parent of minor)

CARBONDALE CHIROPRACTIC INJURY Clinic

Terms of Acceptance

In order to provide the most beneficial healing environment, most effective application of the chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic care.

We ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic.

1. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.
2. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.
3. The chiropractic adjustment process, as defined in the "law of jurisdiction" involves the application of a specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one-million times each day by doctors of chiropractic in the United States alone.
4. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
5. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. The retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
6. Your compliance with the care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
7. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we maintain as a supporting, open environment.

I, _____(print name) have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

(Signature) (Date)

CARBONDALE CHIROPRACTIC INJURY Clinic

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, offers considerable benefits, but it may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/ strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instances per one million to one instance per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health, and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

_____

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care spinal adjustments, as reported following my assessment.

_____ _____

Patient name (printed) Relationship to patient

_____ _____

Patient (or legal Guardian Signature) Date

_____ _____

Witness Signature (Office Staff) Date

CARBONDALE CHIROPRACTIC INJURY Clinic

Notice of Privacy Practices

(Medical)

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordination, or managing health care and related services by one of more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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.

CARBONDALE CHIROPRACTIC INJURY Clinic

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice to Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Relationship to Patient: _____
(Please write "self" if not a dependent)

Date:_____

Patient Name: _____

Signature:_____

CARBONDALE CHIROPRACTIC INJURY Clinic

Consent to Treat and X-Ray

Please fill out the section that pertains to the patient, either section A, B, or C.

A. I _____, Authorize the performance of diagnostic x-ray of myself, which the doctor may consider necessary or advisable in the course of my examination and treatment.

X_____ Date _____

B. Females Only
I certify that to the best of my knowledge I am not pregnant and the doctor has my permission to perform diagnostic x-ray examination.
I have been advised that x-rays can be hazardous to an unborn child.
Date of last menstrual period _____

X_____ Date _____

C. Minors Only: Parent or Legal Guardian please complete this section.

I hereby authorize Carbondale Chiropractic Injury Clinic and whomever he/she designates as his/her assistants to administer treatment as he/she so deems necessary to my child, _____.

Parent/Guardian Signature _____
Date _____

CARBONDALE CHIROPRACTIC INJURY Clinic

Medical Release Form

Patient Name _____

DOB:_____

I, _____, hereby authorize the release of ANY medical records to:

Carbondale Chiropractic Injury Clinic
David Binversie, D.C.
624 E Walnut St.
Carbondale, IL 62901
Phone: 618-519-9334 Fax: 618-549-2694

Please include all of the following records unless specified below by the patient:

I do not wish to include records of the following nature,

_____

_____.

Requesting records from:

Facility Name: _____

Fax Number: _____

Date of Service(s): _____ to _____

SIGNED: _____ DATE:_____