COMFORT CHIROPRACTIC & WELLNESS

ELECTRONIC MEDICAL RECORDS UPDATE FORM

Today's Date:_____

Name: _____ Date of Birth:_____

Address: _____ SS#: _____-_____-_____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Occupation: _____

Gender: Male - Female Race:_____

List any **Allergies**:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs ☐ Latex ☐ Molds ☐ Penicillin ☐ Ragweed/Pollen
☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye ☐ Other: _____

List any **Surgeries**:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist ☐ Other: _____

List **ALL Past Medical History** conditions:

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain ☐ Depression
☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting ☐ Fatigue ☐ Foot Pain
☐ Genetic Spinal Condition ☐ Hand Pain ☐ Headaches ☐ Hearing Problems ☐ Hepatitis ☐ High Blood Pressure
☐ Hip Pain ☐ HIV ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain ☐ Menstrual Problems ☐ Mid-Back Pain
☐ Minor Heart Problem ☐ Multiple Sclerosis ☐ Neck Pain ☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's
☐ Polio ☐ Prostate Problems ☐ Shoulder Pain ☐ Significant Weight Change ☐ Spinal Cord Injury ☐ Sprain/Strain
☐ Stroke/Heart Attack ☐ Other: _____

List all **Medications** & what they are for:_____

_____

List your **Family History**: F=Father M=Mother S=Sister B=Brother C=Child

___ Arthritis ___Asthma ___ Back Pain ___Cancer ___ Depression ___Diabetes ___ Epilepsy ___HBP ___Polio
___ Genetic Spinal Condition ___ Heart Problems ___MS ___Neurological Problems ___ Parkinson's ___Stroke
___ Prostate Problems ___Heart Attack ___Headaches ___ Other: _____

Have you had any auto or other accidents? ___No___Yes Describe: _____

Height:_____
Weight:_____
Normal Temp:_____

BP:_____
Pulse:_____
****OFFICE USE ONLY****

USER NAME:_____
PASSWORD:_____

Date of last physical examination: _____ Family Doctor: _____

May we have your permission to update your medical doctor regarding your care at this office? ____Yes _____No

Do you smoke? ☐ No ☐Yes

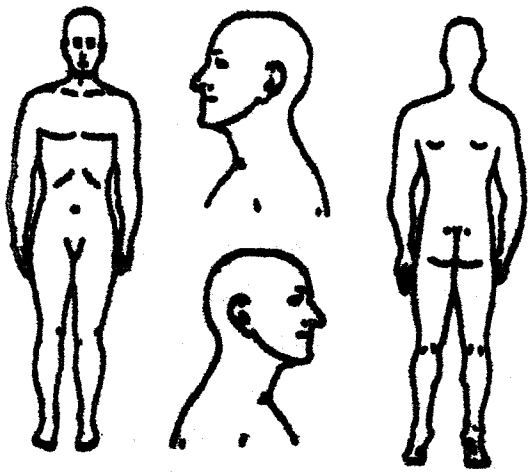
Do you drink alcohol? ☐ No ☐Yes - how many per day? _____

Do you drink caffeine? ☐ No ☐Yes - how many per day? _____

Do you exercise? ☐ No ☐Yes (what forms and how often): _____

Have you had chiropractic care before?_____ When?_____ Why?_____
Where?_____ Were x-rays taken?_____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce symptoms
- ☐ Resume normal activity level

What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Do you have a **SECOND** complaint? _____ Date problem began _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Do you have a **THIRD** complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

COMFORT CHIROPRACTIC & WELLNESS

PATIENT NAME _____ DATE: _____

INFORMED CONSENT

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as couloympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

_____ _____

Patient Signature Signature of Parent/ Guardian

ASSIGNMENT, AUTHORIZATION, & RELEASE

I certify that I, and /or my dependent, have insurance coverage with _____ and assign directly to Dr. Heckes 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.

_____ _____

Patient Signature Signature of Parent / Guardian

HIPPA

The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your patient health information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. The following person (s) have my permission to receive my personal health information:

_____

_____

_____ _____

Patient Signature Signature of Parent / Guardian

RECORDS & TEXT/EMAIL

- o I choose to receive text/email appointment reminders and office news, emails not sold or transferred to third party.
- o I acknowledge that I can request my electronic health records via email or paper within 3 days of my visit.

_____ _____

Patient Signature Email

Comfort Chiropractic and Wellness
Financial Policy

Chiropractic is covered under many insurance plans and health savings accounts. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy *as it applies to your particular situation.*

Patients Without Insurance We request 100% of the first visit be paid at the time of visit unless other arrangements have been pre-arranged and agreed upon. Payment at time of service qualifies for our time of service discount.

Group Or Individual Insurance When possible, we will call to verify benefits on your insurance. We will do to the best of our ability to estimate fees, however, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles, or co-pays.

"On The Job" Injury (Worker's Compensation) If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, any fees and services are due by you immediately.

Personal Injury or Automobile Accidents Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is initiated. Once the claim is settled or if you suspend or terminate care, any fees for services are due by you immediately.

Medicare We do accept assignment from Medicare. The check is usually set directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. Our office completes and files the forms for Medicare at no charge.

Secondary Insurance Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

Insurance One Time Authorization

I understand that my insurance is an arrangement between myself and my insurance company, NOT between Dr. Heckes and my insurance company. I understand that there is no guarantee that my insurance companies, pre-paid health plan, or Medicare will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits, failure to pay for any reason or my insurance does not respond within 60 days. I understand that I am responsible for all remaining charges.

Patient's signature (or guardian if patient is a minor) Date