Chiropractic Case History/Patient Information

Date:_____ Patient #_____ Doctor:_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____Fax #_____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

Please check any and all insurance coverage that may be applicable in this case:

❒ Major Medical ❒ Worker's Compensation ❒ Medicaid ❒ Medicare ❒ Auto Accident
❒ Medical Savings Account & Flex Plans ❒ Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

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 HIPAA 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's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Video____ Scan_____ Tour____ Exam____ XRay: C T L Therapy_____

Checked by Employee:_____

PATIENT NAME _____

DATE _____ Doctor_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? ❒ Yes ❒ No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? ❒ Yes ❒ No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? ❒ Yes ❒ No

If yes, describe:_____

Do you have any allergies of any kind? ❒ Yes ❒ No

If yes, describe:_____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _____

Women: Are you pregnant?_____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

	N = Now	P = Previously	
Headaches_____ Frequency	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____

PATIENT NAME _____

DATE _____ Doctor_____

Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alchoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Depression	_____
Ulcers	_____		

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

PATIENT NAME _____

DATE _____ Doctor_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

ASSIGNMENT OF BENEFITS/AUTHORIZATION

I hereby acknowledge that I am receiving (or about to receive) health care services from Cannon Chiropractic Center, and that the clinic providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. _____ (Initial)

Authorization to File Insurance
I authorize Cannon Chiropractic Center to release any information it deems appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred for services rendered me by Cannon Chiropractic Center or any member of the staff acting on the clinic's behalf. _____ (Initial)

Assignment of Benefits
I authorize the direct payment to Cannon Chiropractic Center of any sum I now or hereafter owe the clinic by any insurance company obligated to reimburse me, and to my attorney, out of the proceeds of any settlement of my case for the charges for services rendered or otherwise obligated to make payment to me or Cannon Chiropractic Center based in whole or in part upon the charges made for services rendered. In the event any insurance company obligated by contractual agreement to make payment to Cannon Chiropractic Center or me for the charges made for services refuses to make such payment upon demand by the clinic, I hereby assign and transfer to Cannon Chiropractic Center the cause of action that exists in my favor against any such company. I authorize Cannon Chiropractic Center to prosecute said action either in my name or the name of the clinic as it deems necessary, and further authorize Cannon Chiropractic Center to compromise, settle or otherwise resolve said claim as it deems necessary._____ (Initial)

Financial Agreements
If an insurance company obligated to pay me or Cannon Chiropractic Center the charges for services rendered refuses to pay upon demand by the clinic, or if there is no insurance company so obligated, then I will pay for services rendered by Cannon Chiropractic Center. I will pay my account in full immediately, or I will keep my account current. If I have a liability claim and my attorney refuse to protect the interest of Cannon Chiropractic Center, or if I have not engaged the services of an attorney, I hereby promise to pay my bill in full within ten (10) days from the date of my liability claim is settled or after the passage of two (2) months from the date of my last treatment, whichever comes first._____ (Initial)

Late Payments
I will be allowed 8 weeks to pay Cannon Chiropractic Center the balance of my bill. If I do not pay within this time period, the clinic will **add a 1.5% late fee to my balance monthly**. I agree to pay all cost of collections if my account becomes delinquent, including attorney fees and all court costs if a lawsuit is filed against me.
_____ (Initial)

Collection Agencies
If for any reason my account is handed over to an outside collection agency I will be held responsible for any and all fees and/or commission charges related to my account/bill. _____(Initial)

If Applicable- Lifetime Authorization to file Medicare
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Cannon Chiropractic Center for any services furnished to me by Dr. Jayson Cannon. I authorize any holder of medical information about me to release to the Health Care Financing and its agents any information needed to determine these benefits or the benefits payable for related services._____ (Initial)

Authorization to Leave Message
I hereby authorize Cannon Chiropractic Center to leave a message at my home regarding pending appointments and/or tests. _____ (Initial)

Patient or Responsible Party: BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE ABOVE

Patient/Responsible Party: _____
(Please PRINT)

SIGNATURE: _____
DATE: _____

HIPPA NOTIFICATION

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Cannon Chiropractic Center, we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis assessment or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
*Your name, address, phone number, and your health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances.

*If we are providing health care services to you based on the orders of another health care provider.
* If we provide health care services to you in an emergency.
* If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
* If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
* If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than is outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of these notices while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy practice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and no longer be protected by the federal rules.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you should direct your complaint to Dr. Jayson Cannon, D.C.

If you would like further information about our policies and practices, please contact us.

This notice is effective as of 4/13/2003. This notice and any alterations or amendments made hereto will expire seven years after the date which the record was created. My signature acknowledges that I received a copy of this notice.

Name (please print)	Signature	Date

If you are a minor, or if you are being represented by another party

Personal Representative (print)	Personal Representative Signature	Date

Description of the authority to act on behalf of the patient

Consent to Examine and Treat

The undersigned consents to any examination (x-ray or otherwise) including, but not limited to, physical, orthopedic and neurological evaluation, visual inspection and palpation.

The undersigned also consents to observation of therapeutic or diagnostic procedures by staff personnel or medical personnel in training as permitted by the attending practitioner and allowed by clinic policy. Treatment procedures that may be used in your treatment include, but are not limited to, manipulative therapy, joint mobilization, myofascial release, trigger-point therapy, ultrasound, diathermy, electrical stimulation, rehabilitative exercise, and massage.

Cases will be managed with all due concern and with the evaluation of response to previous care provided. Home care instructions will be given as appropriate to enhance your treatment program. Compliance with the recommendations for home care and follow-up care is necessary for the resolution of your complaint.

Because of modern techniques and equipment, examination and therapeutic procedures carry with them a low risk of complication. Even though problems seldom arise during these procedures, risks must be recognized and considered. Any procedure intended to help may also do harm. While examination and therapeutic procedures used in this clinic are considered remarkably safe and effective, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate our patients. These complications include but are not limited to pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, bleeding, fracture, fainting, irregular heartbeat, heart attack, spinal cord damage, nausea, burns, soft tissue injury, stroke, dizziness, or weakness. No guarantee or warranty for a specific cure or result is implied by the acceptance of your case. All patients respond differently to the treatment procedures and each case must be evaluated separately.

If you do not fully understand the above or have questions about anything mentioned in this document, please do not sign it until these matters have been resolved with further discussion.

I have read the above explanation of treatment and diagnostic procedures used in this clinic and have myself decided that it is in my best interest to submit to these procedures.

Printed Name_____

Signature_____ Date_____

Witness_____