New Mexico Chiropractic Center

Confidential Patient Health Record

Date:_____/_____/_____

Name:_____ Social Security #:_____
Home Phone:_____ Cell Phone:_____
Address:_____
City:_____ State:_____ Zip:_____
E-mail Address: _____ Fax # _____
Age:_____ Birth Date:_____ Gender: Male____ Female____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____
Employer's Address:_____ Office Phone:_____
Spouse:_____ Occupation:_____ Employer:_____
How Many Children?_____ Ages of Children:_____

Emergency Contact:_____ Phone:_____
Relationship to You:_____

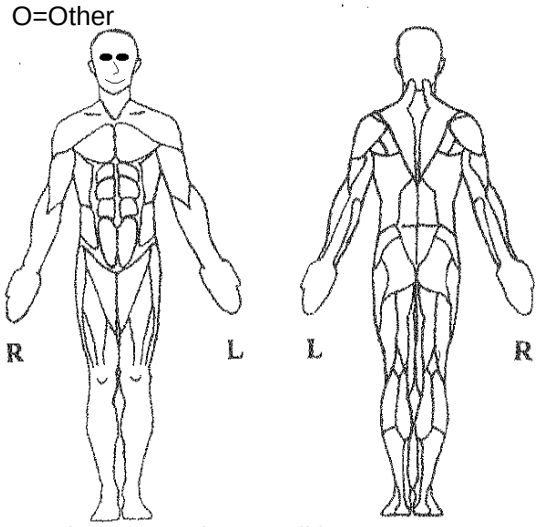
How were you referred to our office?_____

Family Medical Doctor:_____ Phone:_____
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? □ Yes □ No

HISTORY OF PRESENT ILLNESS:

Chief Complaint (Why are you here):_____
_____
Date symptoms appeared: _____/_____/_____
Is this due to: □ Auto □ Work □ Other_____
Have you had this condition in the past? □ Yes □ No
If yes, when and describe:_____
_____
Days lost from work:_____
Date of last physical exam:_____
How frequent is the condition?
□ Constant □ Frequent □ Intermittent
□ Occasional □ Night Only
How long does it last? □ All Day □ Hours □ Minutes
Describe the pain:
□ Sharp □ Aching □ Numbness □ Dull
□ Tingling □ Burning □ Stabbing
□Other_____
Is there anything you can do to relieve the problem?
□ Yes □ No If yes, describe:_____
_____
If no, what have you tried that has not helped?_____
_____
What makes the problem worse?
□ Standing □ Sitting □ Lying □ Bending
□ Lifting □ Twisting □Other_____
_____
Have you seen other doctors for this condition?
□ Yes □ No Type of treatment:_____
If yes, Who? (name)_____
Were you satisfied with your treatment? □ Yes □ No

Use the letters below to indicate the type and the location of your pain or problem:
A=Ache B=Burning N=Numbness
S=Sharp T=Tingling P=Pins and Needles
O=Other



Are there any other conditions or symptoms that may be related to your problem?
□ Yes □ No
If yes, describe:_____
_____
Are there other unrelated health problems?
□ Yes □ No
If yes, describe:_____
_____

WOMEN ONLY:
Are you pregnant or is there any possibility you may be pregnant? □ Yes □ No □ Uncertain
Date of last Menses ____/____/____ My menses is □ Regular □ Irregular
Are you currently taking an oral contraceptive (birth control pill)? □ Yes □ No

PAST MEDICAL HISTORY:
Have you ever been diagnosed as having or have suffered from any of the following? (Place a check mark by conditions that apply to you.)

□Broken or Fractured Bones	□Excessive Bleeding	□Chills
□Osteoarthritis	□A Congenital Disease	□Unintentional Weight Loss
□Strokes	□Gall Bladder	□Fever
□Cancer	□Ruptures	□Night Sweats
□Eating Disorder	□Depression	□Blurred Vision
□Ulcers	□Diabetes	□Dizziness
□Circulatory Problems	□Tuberculosis	□Headaches
□Epilepsy	□Asthma	□Slurred Speech
□Alcoholism	□Kidney Disease	□Numbness
□Coughing Blood	□Kidney Stones	□Facial Weakness
□Pace Maker	□Liver Disease	□Limb Weakness
□Drug Addiction	□Mental Illness	□TMJ Problems
□High/Low Blood Pressure	□Heart Disease	□Abdominal Pain
□Seizures/Convulsions	□Lung Disease	□Blood Clots
□HIV Positive	□Rheumatoid Arthritis	

Please explain any checked conditions:_____
_____
_____

Do you have a history of stroke or hypertension? □ Yes □ No
Have you had any major illness, hospitalization, injury, fall, auto accident or surgery? □ Yes □ No
If yes, explain:_____
_____
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, explain:_____
What medications or drugs are you taking?_____
Do you have any allergies to any medications, nutritional products or food? □ Yes □ No
If yes, describe:_____
Do you have any allergies of any kind? □ Yes □ No
If yes, describe:_____
Please list any other health problems you have, no matter how insignificant they may be:_____
_____

SOCIAL HISTORY:
Do you drink alcoholic beverages? □ Yes □ No If yes, how many drinks per week?_____
Do you use any tobacco products? □ Yes □ No If yes, what kind:_____
Do you smoke? □ Yes □ No If yes, packs per day:_____
Do you take vitamin supplements? □ Yes □ No If yes, please list:_____
Do you consume caffeine? □ Yes □ No If yes, how much per day:_____
Do you exercise? □ Yes □ No If yes, what is the frequency and type of exercise?____
_____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
Lifting_____ Sitting_____ Bending_____ Working at a computer_____

FAMILY HISTORY:

Father: □living deceased
Current age if still living:_____ Cause of death and age at death if deceased:_____
Mother: □living deceased
Current age if still living:_____ Cause of death and age at death if deceased:_____
Check if applicable to you: □As an adopted child, little is known of birth parents or family.
Do you have any family members who suffer from the same condition you do? □ Yes □ No
If yes, please list:_____

FAMILY DISEASES: (Check if applicable and indicate **F**ather, **M**other, **S**ister, **B**rother):

□ Tuberculosis____
□ Cancer____
□ Mental Illness____
□ Diabetes ____
□ Asthma____
□ Heart Disease ____
□ Stroke ____
□ Kidney Disease____
□ Lung Disease____
□ Arthritis_____
□ Liver Disease ____
□ Other____
Explain:_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Notice of Informed Consent

New Mexico Chiropractic Center

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about chiropractic care and the potential problems associated with it before consenting to treatment.

Subluxation is a medical term that describes what occurs when one or more of the spinal (vertebral) joints have moved out of their normal alignment. This can occur through recent or remote trauma as well as unusual positions we may find ourselves in throughout the day or night. A subluxation has also been described as an incomplete dislocation of a joint, and, as such, is not treated with drugs or surgery. Chiropractors treat vertebral subluxation with spinal manipulations (adjustments performed by hand or with the use of a specific tool) in order to gently reposition the misaligned segments. Frequently, adjustments create a popping or a clicking sensation in the area being treated.

Stroke: Recent reports have shown an elevated incidence of stroke is seen equally in chiropractic and medical physician offices (Cassidy, 2008); supporting the theory that patients are presenting with a stroke, and not that chiropractors or medical physicians are causing a stroke.

Disc Herniation: Disc herniations that create pressure on the spinal nerves or the spinal cord in the neck or low back are treated successfully by chiropractors with adjustments and spinal decompression. Occasionally, these treatments can irritate this problem. Patients are thoroughly examined to determine the best course of treatment. Disc herniation complications occur so rarely there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue refers primarily to the muscles, tendons, and ligaments. Muscles move bones, and ligaments limit joint movement. Rarely, a chiropractic adjustment, traction, massage, and other treatments may strain some muscle or ligament fibers. These possible injuries also occur so rarely there are no available statistics to quantify their probability.

Rib Fractures: Your ribs are attached to the thoracic spine in the middle back. They extend from your back to the front of your chest. Rarely, a chiropractic adjustment may break a rib. This could possibly occur only to those patients with weakened bones. It is your responsibility as the patient to inform your doctor of any history of osteoporosis, prolonged steroid use, or other bone-weakening diseases. Rib fractures also occur so rarely there are no available statistics to quantify their probability.

Physical Therapy Irritations: Some therapeutic machines and analgesic balms generate heat. Different forms of heat and ice may be applied in the office and occasionally recommended for use at home. Rarely will

heat or ice irritate the skin. However, everyone's skin has a different sensitivity to these modalities and the application of such may cause a temporary increase of skin pain and possibly some blistering. These possible irritations also occur so rarely there are no available statistics to quantify their probability. **Please be sure to follow the doctor's specific instructions for home application if prescribed.**

Soreness: It is not uncommon for spinal adjustments, Active Release Therapy, exercise, and other therapies to result in a temporary increase in soreness to the area being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please inform the doctor if you experience soreness.

At New Mexico Chiropractic Center (NMCC) we employ highly-trained staff to assist the doctors with portions of your consultation, examination, x-rays, physiotherapy, exercise instruction, and other treatments. Occasionally, when your doctor is not available, another NMCC doctor will be available to treat you.

Any questions on the above information should be directed to your doctor. When you have a full understanding of this material, please sign and date below.

Authorize to Treat: I, the undersigned, hereby authorize all NMCC doctors and whomever they designate to administer chiropractic, physical therapy, and/or therapeutic treatment or medical procedures they consider necessary on the basis of findings during the set course of treatment.

Patient Name:_____ **Date:**_____

Patient Signature:_____ **Witness:**_____

Consent for Treatment of a Minor: I, the undersigned, hereby authorize all NMCC doctors and whomever they designate to administer chiropractic, physical therapy, and/or therapeutic treatment or medical procedures they consider necessary on the basis of findings during the set course of treatment to:

Minor Child's Name:_____ **Date:**_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____ **Witness**_____

Financial Policy

New Mexico Chiropractic Center

Welcome to our office! We are pleased you have chosen Chiropractic for your health care needs. Your health is your greatest asset, and, therefore one of the best things you can invest in financially.

YOUR FIRST VISIT

All services rendered during the first visit **must** be paid for at that time. Patients without insurance coverage may pay by cash, check, electronic debit or credit card. Patients with insurance must pay for their deductible and/or co-payment or co-insurance by cash, check, electronic debit or credit card provided their coverage has been verified. **Patients with insurance that has not been verified are on a cash basis until coverage is confirmed.**

Patient Initial:_____

We gladly accept insurance assignment if the insurance company: 1.Verifies the deductible (if there is one) has been met, 2. Provides details of the available coverage, and 3. Agrees to make payment directly to our office. It must be understood; insurance is an agreement between the patient and the insurance company. The agreement is **not** between the insurance company and this office. In every case, the patient or their guardian is ultimately responsible for all fees. Our office will file the necessary primary claim forms at no charge. Some insurance companies require special forms and will not accept universal claim forms. Assistance with additional forms and policies may be subject to a small clerical fee. In these cases, the patient is responsible for supplying the required forms with the patient's portion completed and signed.

Patient Initial:_____

PRIVATE HEALTH INSURANCE POLICIES

Patients with private health insurance policies of which the doctor is a contracted provider for are responsible for deductibles, co-payments, co-insurance and non-covered services. All services rendered during office visits must be paid for at that time. Many private health insurance policies have visit limitations, maximum daily payout limitations, and/or calendar or contract year dollar amount limitations. If, at any time during the course of treatment, all insurance benefits have been exhausted, the patient will be treated on a cash basis.

Patient Initial:_____

PERSONAL INJURY/AUTOMOBILE ACCIDENT

We will accept Med-Pay (medical coverage on your auto insurance policy) and Third party cases**. It is the policy of this office to file Med-Pay before any third-party insurers.** It is the patient's responsibility to provide our office within the first week of care, the insurance company information, claim number, phone number and billing address. Med-Pay will cover medical expenses regardless of who was at fault. Our office will bill your auto insurance company for prompt and direct payment for your care up to your policy limits. If an attorney is handling your case, we will accept a Letter of Protection (LOP) at our discretion. The patient is ultimately responsible for all services rendered in our office and will be required to provide a credit-card guarantee or authorization for electronic debit. **If the patient suspends or terminates care, all fees for services are due immediately.**

Patient Initial:_____

"ON THE JOB INJURY"/WORKERS COMPENSATION
Worker's Compensation patients may be accepted by our office once proper authorization has been granted by the patient's worker's compensation adjuster. It is the patient's responsibility to supply our office, prior to any care being given, with the claim number and billing address and adjuster's name and phone number. The patient is ultimately responsible for all services rendered in our office and will be required to provide a credit-card guarantee or authorization for electronic debit. **If the patient suspends or terminates care, all fees for services are due immediately.**

Patient Initial:_____

CASH PAYMENT
Patients without insurance coverage must pay for care by cash, check, electronic debit or credit card. Payment is due at the time services are rendered.

Patient Initial:_____

AFTER HOURS/EMERGENCIES
Emergency care after hours or on weekends and holidays is available. Please be aware that after hours calls are subject to additional charges, which are not covered by insurance carriers. These charges are in addition to the services rendered and the patient is solely responsible for their payment.

Patient Initial:_____

MISSED APPOINTMENTS
Our office reserves the right to charge a $25.00 per appointment fee to any patient who exhibits a pattern of missed appointments. The doctors in our office are often scheduled out several weeks in advance and missed appointments without prior notification are a loss for everyone. It is the patient's sole responsibility for any charges resulting from missed appointments. Such charges are not covered by insurance carriers. (Unexpected emergencies will be given due consideration before charges are incurred.)

Patient Initial:_____

PAST DUE ACCOUNTS/ COLLECTIONS
If necessary, statements will be issued to patients with outstanding account balances. Payment of balances owed may be made in person, by phone or by mail. It is our expectation that outstanding balances will be taken care of in a timely manner. Delinquent accounts are reported to credit reporting agencies and/or an attorney for collections. If your account is sent to collections, you will be responsible for any fees associated with that process.

Patient Initial:_____

REFUNDS
In the event of an overpayment, a credit will be applied to your account for your future health maintenance needs. The credits will be applied when our office receives final payment from the insurance carrier and active care has been completed.

Patient Initial:_____

ASSIGNMENT OF BENEFITS
Assignment of benefits simply means that the patient gives their permission to the insurance carrier to make payments directly to our office. Cash patients are not subject to assignment of benefit agreements. The patient who does not wish to assign benefits to our office will be treated as a cash patient.

Patient Initial:_____

RELEASE OF INFORMATION
All patients who assign benefits to our office must sign a release of information form. This form gives our office permission to release information about the patient's health that may be required by the insurance carrier in order to provide benefits. Patients who do not wish to have their health information released and do not sign an information release, cannot assign benefits. This means the patient will not be able to use their insurance and payment will be on a cash basis. Cash patients do not have to sign an information release. Please note that the information release for our office is written to cover a variety of insurance cases. If there is anyone a patient does not want information released to, our office should be informed **immediately!**

Patient Initial:_____

I have read, understand and agree to abide by the terms of this office's Financial Policy. Any portion of this agreement that is found to be void or invalid will have no effect on other portions of this agreement.

Patient's Name:_____

Patient's Signature:_____

Date:_____

Witness: _____

Witness's Signature: _____

New Mexico Chiropractic Center
10555 Montgomery Blvd. NE, Building 1, Suite 30
Albuquerque, NM 87111
Phone (505) 299-6622 Fax (505) 323-4419

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR AND RELEASE OF INFORMATION

Patient:_____

Insured SS# or ID#_____

Claim/Group#:_____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

New Mexico Chiropractic Center

as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. The payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

New Mexico Chiropractic Center
10555 Montgomery Blvd. NE, Building 1, Suite 30
Albuquerque, NM 87111

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated at_____this_____day of _____, _____
(Location)

_____ _____
Insured Witness

X-RAY PREGNANCY WAIVER

I hereby acknowledge New Mexico Chiropractic Center has informed me prior to being x-rayed of the risk and the probable consequences of receiving x-rays during pregnancy. Prior to being x-rayed, I state of my own volition I am not pregnant and do hereby release and hold harmless New Mexico Chiropractic Center from any legal action or responsibility associated with the x-ray procedure.

_____

Printed Name of Patient

_____ _____

Signature of Patient/Authorized Rep. of Patient Date

_____ _____

Witness Date