

Saum Chiropractic Clinic Case History/Patient Information

Today's Date: _____ Case Number # _____ CA/Doctor: _____

Name: _____ Social Security #: _____ Age: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Home # _____ Cell # _____

Gender: M F Preferred Contact Home Work Cell Cell Carrier/Company: _____

Do we have permission to contact you occasionally by text message for appointment reminders, etc. ? Y N

Occupation: _____ Employer: _____

Employer's Address: _____ Work Phone: _____ Ext: _____

Marital Status: M S W D Spouse: _____ Employer: _____

Spouse Employer Address: _____ Spouse Work #: _____

of children? _____ Names and Ages of Children: _____

Emergency contact: _____ Relationship to emergency contact: _____

Emergency contact number: _____

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? Y N

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 and Date of Birth of Insured/Employee: _____

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: _____

NAME _____ DATE _____ DOCTOR _____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint(s)/Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto ___ Work ___ Other _____

The severity of your complaint/concern is: Mild Mild-moderate Moderate Moderate-severe Severe

The frequency of complaint/concern is: Occasional Intermittent Frequent Constant

Describe the pain: Achy Burning Dull Sharp Shooting Stabbing Throbbing Other _____

On a scale of 0 to 10, how would you rate your pain/symptoms today? (please circle a number below)

None=0 1 2 3 4 5 6 7 8 9 10=Worst possible

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

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 (give dates and descriptions): _____

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

If yes, describe: _____

What medications, drugs, or supplements are you taking (remember to list ALL drugs including: aspirin, antibiotics, insulin, birth control, blood pressure, etc.)? _____

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 conditions? Yes No If YES, describe: _____

Women: Are you pregnant? Yes No

SOCIAL HISTORY

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

_____ Exercise _____ Family Pressures _____ Financial Pressures
_____ Alcohol Use _____ Other Mental Stresses _____ Caffeine
_____ High Stress Activities _____ Tobacco Use Other (specify) _____

NAME _____ DATE _____ DOCTOR _____

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**, **P** if you have had these conditions **previously**, and **N/A** if the condition is **not applicable** to you.

N = Now	P = Previously	N/A = Not Applicable
Headaches	_____	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 _____
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 _____
Low Blood Pressure	_____	Osteoarthritis _____
Osteoporosis	_____	Ulcers _____
Pacemaker	_____	Heart Disease _____
Stroke	_____	Cancer _____
Gall Bladder Problems	_____	Other _____

Please indicate which activities of daily living are affected by your current state of health:

- General:**
- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Sitting | <input type="checkbox"/> Climbing stairs | <input type="checkbox"/> Chewing |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Standing | <input type="checkbox"/> Lifting children |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Swimming | <input type="checkbox"/> Playing instrument | <input type="checkbox"/> Using telephone |
| <input type="checkbox"/> Running | <input type="checkbox"/> Bending | <input type="checkbox"/> Lying in bed | <input type="checkbox"/> Using keyboard |
| <input type="checkbox"/> Exercising | <input type="checkbox"/> Sitting in recliner | <input type="checkbox"/> Sports | <input type="checkbox"/> Sewing or crafts |
| <input type="checkbox"/> Getting into/out of an automobile | <input type="checkbox"/> Recreational Activities | | |

- Housework:**
- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Doing laundry | <input type="checkbox"/> Making beds | <input type="checkbox"/> Vacuuming | <input type="checkbox"/> Washing dishes |
| <input type="checkbox"/> Ironing | <input type="checkbox"/> Carrying groceries | <input type="checkbox"/> Caring for pets | <input type="checkbox"/> Cooking |

- Yardwork:**
- | | | | |
|--------------------------------------|--|------------------------------------|------------------------------------|
| <input type="checkbox"/> Mowing lawn | <input type="checkbox"/> Raking leaves | <input type="checkbox"/> Gardening | <input type="checkbox"/> Shoveling |
|--------------------------------------|--|------------------------------------|------------------------------------|

- Grooming:**
- | | | | |
|---------------------------------------|----------------------------------|--|---|
| <input type="checkbox"/> Combing hair | <input type="checkbox"/> Shaving | <input type="checkbox"/> In/out of bathtub | <input type="checkbox"/> Brushing teeth |
|---------------------------------------|----------------------------------|--|---|

- Travel:**
- | | | | |
|--|--|--------------------------------|--------------------------------|
| <input type="checkbox"/> Driving a car | <input type="checkbox"/> Riding in a car | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
|--|--|--------------------------------|--------------------------------|

How often does your job involve lifting? Never Occasionally Frequently Constantly

Other job requirements (please check all that apply): Bending Carrying Stooping

Twisting Turning Walking Other: _____

What is your primary work position? Seated Standing Other: _____

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	MOTHER	SPOUSE	BROTHER(S)		SISTERS		CHILDREN	
	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []
Arthritis									
Asthma-Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problem									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
High Blood 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: _____

Have you seen a chiropractor before? Y N – if Yes, whom? _____
 For what condition? _____ When was your last adjustment? _____

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

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

**Saum Chiropractic Clinic
111 Alabama Street
Columbus, MS 39702
662-327-6586**

**Patient Acknowledgement and Receipt of
Notice of Privacy Practices Pursuant to HIPAA and Consent
for Use of Health Information**

Name _____ Date _____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20____

By _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By _____
Signature of Parent/Guardian (circle one)

**Saum Chiropractic Clinic
111 Alabama St.
Columbus MS, 39702
(662) 327-6586**

Patient Name: _____

Patient #: _____

PAYMENT POLICY INFORMATION

Payment for Services will be by: Cash _____ Check _____ Credit Card _____

Chiropractic Services provided in this office are payable the day services are rendered unless other arrangements have been made prior to seeing the doctor.

1. Patients are personally responsible for all charges. If the staff is unable to verify insurance benefits prior to the end of your first visit, payment is due in full.
2. There will be a \$5.00 charge for paperwork above and beyond the normal claims information needed to process group or individual insurances or if more than 2 (two) insurances are involved.
3. Payment Plan is available upon approval of credit extension by the Office Manager. I authorize a credit check if credit is extended.
4. Assignment of Insurance benefits will be accepted upon proper verification of coverage and at the discretion of this office. There will be verification of coverage; however **"benefits quoted are not a guarantee of payment."** Benefits are determined at the time of processing.
5. Any balance remaining after 60 days with no action on the account will be charged an 18% per annual service charge.
6. A collection fee equal to 40% of balance will be added to all delinquent accounts over 90 days past due that have been sent to a collection agency.
7. I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports at no charge to assist in collecting from my insurance company.
8. If mine is a regular insurance case, I agree to pay a percentage of services as they are rendered. 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.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY:

PATIENT'S SIGNATURE: X _____
(OR GUARDIAN/GUARANTOR)

Date: _____

Witness's Signature: _____

Date: _____