SPANISH FORT CHIROPRACTIC

Dr. Ryan M. Lawrence, D.C.

Patient Health Record

Account #_____

Date:_____

Please fill out our confidential patient health record completely and accurately. All of the information is needed for billing and record keeping purposes. If you have any questions, please don't hesitate to ask one of our qualified chiropractic assistants.

It is our pleasure to be of service to you! Our commitment to you is to promote abundant life through better health.

ABOUT THE PATIENT

Name: _____

Address: _____

City: _____State: _____Zip: _____

Phone: Home: (___)_____ Cell : (___)_____

Email address: _____

Birthdate: _____ Age: _____ Gender: ❑M ❑ F

Social Security #_____

Marital Status ❑Married ❑Single ❑Divorced ❑Separated ❑Widowed

Number of Children: _____ Are you a student? ❑Y ❑N

Employer: _____

Type of Work: _____

Work Phone: (___)_____

ABOUT THE INSURED PERSON

If you are using insurance for your care, we need some information about the person who holds the insurance policy. If the patient is the policyholder, please leave the following information blank and check here: ❑

If the patient is not the policyholder, please provide the following information about them:

Name: _____

Address: _____

City: _____State: ____ Zip: _____

Phone: _____

SSN: _____ Birthdate: _____

Patient's relationship to the insured person:

❑Spouse ❑Child ❑Other: _____

EXPERIENCE WITH CHIROPRACTIC

How did you hear about Spanish Fort Chiropractic?

_____

Have you been adjusted by a Chiropractor before? ❑Yes ❑No

If yes, Doctor's name: _____

Approximate date of last visit: _____

Type of Treatment and results: _____

_____

EMERGENCY CONTACT:

Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Reason for this Visit

Tell us about your symptom(s): _____

Is the purpose of this visit related to: ❑Job ❑Sports Injury ❑Auto Accident ❑Home Injury

❑Chronic Discomfort ❑Fall ❑Other, Please explain: _____

If job or auto related, have you made a report of your accident to your employer or insurance agent? ❑Yes ❑ No

When did this condition begin? _____

Has this condition: ❑Gotten worse ❑Stayed the same ❑Comes and goes

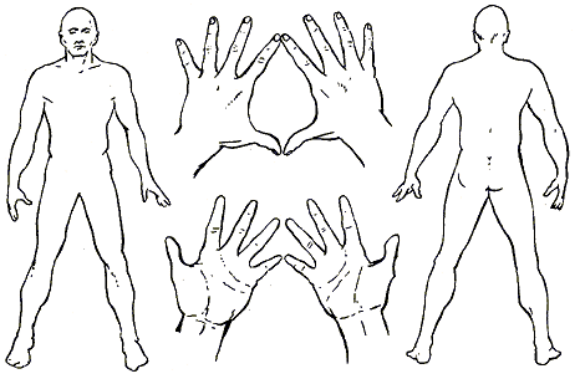
Does this condition interfere with: ❑Work ❑Sleep ❑Daily Activities ❑Other: _____

Has this condition occurred before? ❑Yes ❑No If yes, when: _____

Have you seen any other health care providers for this condition? ❑Yes ❑ No

If yes: Provider's Name(s): _____

Type of treatment and results: _____



Use these symbols to show us where your symptoms are on the diagram.

Sharp pain:	/ / / / / /
Dull/aching pain:	✓✓✓✓✓✓
Stabbing pain:	△△△△△
Weakness:	# # # # # #
Numbness:	+ + + + + +
Burning:	X X X X X X
Pins and needles:	O O O O O O

Medications Patient Takes

❑Nerve Pills ❑Muscle Relaxers

❑Pain Killers (including Aspirin)

❑Blood Pressure Medicine

❑Anti-inflammatory Medicine

❑Stimulants ❑Blood Thinners

❑Tranquilizers ❑Insulin

❑_____ ❑_____

Health Habits

Do you smoke? ❑No ❑Yes: _____packs/day/wk

Do you drink alcohol? ❑No ❑Yes: _____drinks/day/wk

Do you drink coffee? ❑No ❑Yes: _____cups/day/wk

Do you exercise regularly? ❑No ❑Moderate ❑Daily

Check any of the following that you wear:

❑Heel /Sole Lifts ❑Inner Soles ❑Arch Supports

❑Neck Brace ❑Low Back Belt/Brace ❑Other_____

Health Conditions

Please check each of the conditions or diseases that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care and the possibility of being accepted for care.

❑Headaches
❑Sinus Problems
❑Dizziness
❑Neck Pain
❑Pain between the Shoulders
❑Numbness or pain in arms/hands
❑Low back pain
❑Numbness or pain in legs/feet
❑Arthritis

❑Digestive problems
❑Ulcers/Colitis
❑Heart Attack/MI
❑Stroke
❑Heart Surgery
❑Heart Murmur
❑High Blood Pressure
❑Low Blood Pressure
❑Difficulty Breathing
❑Asthma
❑Surgical Implants:
Please explain_____

❑Thyroid Problems
❑Drug/Alcohol Abuse
❑HIV/AIDS
❑Diabetes
❑Tuberculosis
❑Shingles
❑Kidney Problems
❑Hepatitis
❑Cancer
❑Loss of Sleep

For Women:

Are you pregnant? ❑Yes ❑No

Are you nursing? ❑Yes ❑No

Are you taking birth control? ❑Y ❑N

Do you have breast implants? ❑Y ❑N

FAMILY HISTORY:

Does anyone in your immediate family have:

❑Heart Disease ❑Diabetes
❑Cancer ❑Arthritis
❑Neck Pain ❑Low back pain

Informed Consent to Chiropractic Treatment

Thank you for choosing Spanish Fort Chiropractic. We look forward to providing you with the most comprehensive chiropractic care available. Please take a few minutes to read over the following consent. If you have any questions about the consent, please ask us, we will be glad to answer any questions or concerns you may have.

The nature of Chiropractic Treatment: The doctor will use his hands or a mechanical device in order to adjust your joints. You may feel a "click" or a "pop," such as the noise you would hear when you crack your knuckles. Various ancillary procedures, such as hot and cold packs, or traction may also be used during your treatment.

Possible Risks: As with any health care procedure, complications are possible following chiropractic manipulation or adjustment. Complications could include fractures, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries in the neck. Patients may experience stiffness or soreness after the first few days of treatment. The ancillary modalities could produce skin irritation, burn, or other minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from taking a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be further reduced by screening procedures during your initial examination. The probability of adverse reactions due to ancillary procedures is also considered rare.

Risks of Remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make further rehabilitation more difficult. Failure to follow your Doctor's recommended treatment plan may decrease your ability to get well, and may aggravate your present condition.

We do not offer to diagnose or treat any disease. We offer to diagnose vertebral subluxations, segmental dysfunctions or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a specialized health care provider.

I have read the explanation above about chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment and have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

X_____ **Date:** _____

Patient or Guardian Signature

Patient Health Information Consent Form – HIPPA Consent

We want you to know how your patient health information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

X_____ **Date :** _____

Patient or Guardian Signature

Spanish Fort Chiropractic Financial Policy and Assignment of Benefits / Release of Information

It is the goal of this office to provide you with the finest quality chiropractic care available. We are committed to your care at this office. It is our desire to assist our patients whenever possible. The following allows you, our valued patient, to receive the care you need without undue financial strain. Below is a statement of our financial policy, which we require you to read and sign prior to service.

All patients must complete our information and insurance form before seeing the doctor.

1. The privilege of insurance assignment begins when our office has qualified your insurance coverage. For your convenience, we will bill your insurance company directly and accept assignment. As always, you have the option of billing your own insurance if necessary. In a case in which you receive payment from your insurance carrier you must bring the check to the office **within 5 business days of receipt** and endorse it over to this office to be applied to your balance.
2. This office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office nor will we enter into any dispute with an insurance company over the amount of reimbursement. In the event the insurance company denies the claim, it is your responsibility to pay the charges and seek reimbursement from your insurance company.
3. Ultimately the patient is responsible for all services rendered including those not reimbursed by third party payers.
4. All co-payments and deductibles must be paid when services are rendered as this office has adopted a **ZERO BALANCE** policy. For your convenience, advance payment plans are available.
5. Since we do not own your policy and occasionally we experience difficulty in collecting from the carrier, we may ask for your active assistance in rectifying this situation after 60 days.
6. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1.5% per month.
7. All accounts not paid within 90 days will receive final notification and be turned over to a collection agency for further action.

By signing below, I agree to the policies stated here in order to adhere to the **ZERO BALANCE POLICY.** I have read the above, understand it fully, and agree to adhere to these policies.

I hereby authorize payment *directly to the provider* of any and all benefits for charges for examinations and / or treatment received by my dependents or me. I also authorize benefit payers to release any and all information requested regarding such benefits and payment to the provider above. I also authorize the above provider to release medical and other information as may be required to obtain benefits for charges for examinations and / or treatment by my dependents or me.

X_____ **Date :** _____

Patient or Guardian Signature