

NEW PATIENT REGISTRATION

Patient First Chiro. & P.T.

Please print clearly to help avoid billing errors

Patient Last Name _____ First _____ MI _____

Mailing Address _____ Apt or Unit # _____

City _____ State _____ Zip _____

(_____) _____
Home Telephone _____ Cell Number _____ Work Telephone _____

Check Box if you would like to receive our free monthly newsletter via e-mail

Email Address _____

Date of Birth _____ Age _____ Social Security # _____

Marital Status: Single Married Divorced Other _____ Sex: Male Female _____

Employment Status: Employed Full Time Employed Part Time Full Time Student Unemployed Retired _____

INSURANCE SUBSCRIBER / GUARANTOR NAME-Person to Bill if Other Than Patient _____

Mailing Address _____ Apt or Unit # _____ City _____ State _____ Zip _____

Assignment and Release: I hereby authorize and direct my insurance benefits to be paid directly to Patient First Chiro. & P.T. I also understand I am financially responsible for any and all non-covered services provided by Patient First Chiro. & P.T.

*** **IMPORTANT:** Who is your Primary Care Physician: _____

Signature: _____ Date: _____

***** Below for Office Use Only *****

DIAGS: (1) _____ (2) _____ (3) _____ (4) _____

INITIAL VISIT PROCEDURES – CHIRO / P.T

Date of Service: _____ Amount Paid This Visit: \$ _____ Provider: BC MO NT LC RG NH

New Chiro. Exam: 99202 99203 99204 99205 _____ New P.T. Exam: 97001

9894 _____ 97014 _____ 97110 _____ 98943 _____ 97140 _____ 97010 _____ 97035 _____ 97112 _____
Manip. E-Stim – Un Thera. Ex. Extra Spine Man. Thera. H/C Packs Ultrasound Neuro Re-Ed

Check Box to **Block Pt. Statements**

PATIENT AUTHORIZATION

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Signed: _____ Date: _____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies our staff is trained to inform you of the financial policies of this office. Payment is expected from you at the time of service for "your part" of the charges. We accept payment in the form of cash, check, VISA or MasterCard for your convenience. Your signature below indicated that you understand and accept this policy.

Signed: _____ Date: _____

Do we have permission to:

- | | | |
|---|------------------------------|-----------------------------|
| Leave a message on your answering machine at home? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Leave a message at your place of employment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Leave a message using your e-mail address? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Discuss your medical condition with any member of your household?
If yes, whom?: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Signed: _____ Date: _____

I have been given a copy of the Privacy Practices/HIPPA.

Signed: _____ Date: _____

FOR HMO AND MANAGED CARE PLANS ONLY:

As a member of a managed care plan, I understand I have an obligation to have all medical care coordinated by my PCP. I understand I must obtain a referral from my primary care physician before seeing a Physical Therapist. I understand that I will be personally responsible for payment for services received if denied by my insurance carrier or if I do not have a referral from my PCP for any service dates.

Signed: _____ Date: _____

FOR MEDICARE ONLY:

I authorize any holder of medical or other information about me to release the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signed: _____ Date: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associations (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment: We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations: We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice of the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Medical Information

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications: You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures: You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice with the effective date in the upper right corner of the first pane.

Verification of Claims Information

Personal Injury / Worker's Compensation

Patient: _____ DOI: _____

Insurance
Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____

Claim Number: _____

Adjuster: _____ Phone: _____

Attorney Information

Law Firm: _____

Attorney Name: _____

Phone Number: (_____) _____ Fax: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

Health Insurance Affidavit

In order for this office to process your claim efficiently, it is necessary to obtain the following information regarding other health benefits available to you.

Any medical expenses in excess of \$ 2,000.00 will not be paid under your auto policy if those expenses will be compensated, paid or indemnified by an outside insurance carrier.

Bills submitted to your Auto Insurance carrier over the \$ 2,000.00 limit must be accompanied by an Explanation of Benefits from your health carrier or a copy of this Affidavit.

If you have health insurance benefits available to you, please complete section one.

If you **DO NOT** have health benefits available to you, **Please Sign & Date Section Two**

SECTION ONE: (Complete if you have Health Ins.)

Health Insurance Company: _____

Policy Number: _____

Signature: _____ Date: ____ / ____ / ____

SECTION TWO:

I hereby certify that **I DO NOT** have any accident and/ or health benefits available to me through my own policy or that of a household member.

Signature: _____ Date: ____ / ____ / ____

Chiropractic Informed Consent

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. Following are the known risks:

Temporary soreness or increased symptoms or pain. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

Dizziness, nausea, flushing. These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

Fractures. When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Disc herniation or prolapse. Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke. A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visit, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before their stroke.

Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

I have read or had read to me this informed consent document. *I have discussed or been given an opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction **prior to my signing this informed consent document.*** I have made my decision voluntarily and freely.

Signature of Patient or Guardian

Date

Signature of Witness

Based on my personal observation and the patient's history and physical exam, I conclude that throughout the informed consent process the patient was:

- Of legal age
- Consent given through Guardian
- Oriented x3
- Appears unimpaired
- Fluent in English
- Assisted by a translator or interpreter

_____, D.C.
Signature of Chiropractor

Date

Signature of Translator or Interpreter, If applicable

AUTOMOBILE ACCIDENT PAPERWORK:

Name: _____ Date: ____ / ____ / ____

In your own words described what happened: _____

Date of the accident? ____ / ____ / ____ Location of accident: _____

What was your position? (circle one): driver / middle front / passenger / middle back / left rear / right rear

What was the speed of your vehicle? _____ m.p.h. What was the speed of the other vehicle? _____ m.p.h.

Damage to the vehicle you were riding in? (circle one): mild / moderate / extensive / totaled

What was the weather condition? (circle all that apply): snowing / raining / windy / foggy / clear

Who hit who/what? (circle one): I hit the other vehicle / the other vehicle hit me,

I hit the other object – what was the object? _____

What was the point of impact? (circle one): front / rear / left front / left rear / left side / right front / right rear / right side

Were you wearing a seatbelt? Yes / No Were you using the shoulder harness? Yes / No

Does the vehicle have an airbag? Yes / No Was the airbag deployed? Yes / No

Did you strike anything on the vehicle? Yes / No.

If yes, what part of the car did you hit? (circle all that apply): wheel, windshield, armrest, dashboard, side door, side window, airbag. What part of your body hit? _____

Did you see the accident coming? Yes / No.

Does the vehicle have headrests? Yes / No

What was the headrest position? (circle one): even with top of head, even with bottom of head, middle of neck

Were you braced for impact? Yes / No Were you dazed after the accident? Yes / No

Did you lose consciousness? Yes / No If yes for how long? _____

What was the direction of your head? (circle one): facing straight forward / looking to the right / looking to the left

Was your head injured? Yes / No Any other body part injured? _____

Immediately after the accident did you experience any pain? (circle all that apply):

Headaches / neck pain / lower back pain? Other?: _____

Did you go to the hospital? Yes / No If yes, which one? _____

How did you get to the hospital? (circle one): ambulance / I drove myself / someone drove me / police.

What tests were done at the hospital (circle all that apply): x-ray / MRI / CT / lab work

Did you visit any other doctors concerning this accident before coming here? Yes / No

Dr. _____ What tests were performed? _____

Is your condition (circle one): improving / getting worse / staying the same

Have you lost time from work due to this accident? Yes / No If yes for how long? _____

Can you perform physical work activities? Yes / No

If no, why not? (circle all that apply): Pain, weakness, stress, other _____

Are you having problems (check all that apply):

- seeing tasting smelling eating hearing bathing grooming
- dressing reading typing writing grasping holding pinching
- standing leaning walking stooping squatting climbing kneeling
- bending twisting carrying lifting pushing pulling reaching
- sitting driving riding in car air travel sports exercising loss of sexual drive
- reclining restful sleeping insomnia using the toilet loss of concentration
- nervous irritable change in personality tactile feeling

Additional activities of daily living that you are having problems with: _____

Can you go to sleep without problems? Yes / No Do you awaken because of pain? Yes / No If yes where? _____

Have you had sleep problems before? Yes / No

What is your occupation? _____ Do you perform regular or light duty? _____

Are the injuries from this accident a financial burden for you and your family? Yes / No If yes explain how _____

Have you been in an accident before? Yes / No If yes what year? _____

Who treated you? _____ Any residual problems? _____

Past Medical History: _____

Past Surgical History: _____

Family: _____

Current Medications: _____

Allergies: _____

Social History.

Marital Status (circle one): married / single / widowed / divorced / separated

Do you have children? Yes / No Are you pregnant? Yes / No / Does not apply

Do you smoke? Yes / No. If yes how many packs per day? _____

Do you drink alcohol? Yes / No. If yes, how many drinks per week? _____

Do you drink coffee? Yes / No. If yes, how many cups per day? _____

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I understand and agree that all services rendered time are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care/treatment, any fees for services rendered me will be immediately due and payable

Patients Signature: \_\_\_\_\_ S.S. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Complaint 1 (example neck, mid or low back pain, etc): \_\_\_\_\_

How would you rate your pain? 0 = no pain, 10 = worst pain imaginable (circle one)

0      1      2      3      4      5      6      7      8      9      10

Did this complaint come on gradually or immediately? \_\_\_\_\_

Is your condition getting (circle one): better / worse / same.

Intensity (circle one): minimal, slight, moderate, severe

How often do you experience the pain/discomfort? (circle one):

comes and goes /some of the time / most of the time / all of the time

How would you describe the feeling (circle all that apply):

dull            sharp            aching            shooting            spasm            throbbing            burning  
numbing      tingling            other:\_\_\_\_\_

Actions that effect this complaint: mark "A" for Aggravate, "R" for relieves, or leave blank

\_\_\_ in the morning      \_\_\_ in the afternoon      \_\_\_ bending forward      \_\_\_ bending back      \_\_\_ bending left  
\_\_\_ bending right      \_\_\_ twisting left      \_\_\_ twisting right      \_\_\_ coughing      \_\_\_ sneezing  
\_\_\_ straining      \_\_\_ standing      \_\_\_ lifting      \_\_\_ sitting      \_\_\_ heat  
\_\_\_ cold      \_\_\_ rest      \_\_\_ lying down      \_\_\_ medications

Other actions that make your condition better or worse? \_\_\_\_\_

Does your pain travel to other areas of your body? Head / neck / shoulder / arm / hand / hip / leg / foot

Also travels to: \_\_\_\_\_

~~~~~  
Complaint 2 (example neck, mid or low back pain, etc): _____

How would you rate your pain? 0 = no pain, 10 = worst pain imaginable (circle one)

0 1 2 3 4 5 6 7 8 9 10

Did this complaint come on gradually or immediately? _____

Is your condition getting (circle one): better / worse / same.

Intensity (circle one): minimal / slight / moderate / severe

How often do you experience the pain/discomfort? (circle one):

comes and goes /some of the time / most of the time / all of the time

How would you describe the feeling (circle all that apply):

dull sharp aching shooting spasm throbbing burning
numbing tingling other:_____

Actions that effect this complaint: mark "A" for Aggravate, "R" for relieves, or leave blank

___ in the morning ___ in the afternoon ___ bending forward ___ bending back ___ bending left
___ bending right ___ twisting left ___ twisting right ___ coughing ___ sneezing
___ straining ___ standing ___ lifting ___ sitting ___ heat
___ cold ___ rest ___ lying down ___ medications

Other actions that make your condition better or worse? _____

Does your pain travel to other areas of your body? (circle): head / neck / shoulder / arm / hand / hip / leg / foot

Also travels to: _____

Complaint 3 (example neck, mid or low back pain, etc): _____

How would you rate your pain? 0 = no pain, 10 = worst pain imaginable (circle one)

0 1 2 3 4 5 6 7 8 9 10

Did this complaint come on gradually or immediately? _____

Is your condition getting (circle one): better / worse / same.

Intensity (circle one): minimal, slight, moderate, severe

How often do you experience the pain/discomfort? (circle one):

comes and goes /some of the time / most of the time / all of the time

How would you describe the feeling (circle all that apply):

dull sharp aching shooting spasm throbbing burning
numbing tingling other: _____

Actions that effect this complaint: mark "A" for Aggravate, "R" for relieves, or leave blank

___ in the morning ___ in the afternoon ___ bending forward ___ bending back ___ bending left

___ bending right ___ twisting left ___ twisting right ___ coughing ___ sneezing

___ straining ___ standing ___ lifting ___ sitting ___ heat

___ cold ___ rest ___ lying down ___ medications

Other actions that make your condition better or worse? _____

Does your pain travel to other areas of your body? Head / neck / shoulder / arm / hand / hip / leg / foot

Also travels to: _____

~~~~~  
Complaint 4 (example neck, mid or low back pain, etc): \_\_\_\_\_

How would you rate your pain? 0 = no pain, 10 = worst pain imaginable (circle one)

0    1    2    3    4    5    6    7    8    9    10

Did this complaint come on gradually or immediately? \_\_\_\_\_

Is your condition getting (circle one): better / worse / same.

Intensity (circle one): minimal / slight / moderate / severe

How often do you experience the pain/discomfort? (circle one):

comes and goes /some of the time / most of the time / all of the time

How would you describe the feeling (circle all that apply):

dull            sharp            aching            shooting            spasm            throbbing            burning  
numbing        tingling            other: \_\_\_\_\_

Actions that effect this complaint: mark "A" for Aggravate, "R" for relieves, or leave blank

\_\_\_ in the morning    \_\_\_ in the afternoon    \_\_\_ bending forward    \_\_\_ bending back    \_\_\_ bending left

\_\_\_ bending right    \_\_\_ twisting left    \_\_\_ twisting right    \_\_\_ coughing    \_\_\_ sneezing

\_\_\_ straining    \_\_\_ standing    \_\_\_ lifting    \_\_\_ sitting    \_\_\_ heat

\_\_\_ cold    \_\_\_ rest    \_\_\_ lying down    \_\_\_ medications

Other actions that make your condition better or worse? \_\_\_\_\_

Does your pain travel to other areas of your body? (circle): head / neck / shoulder / arm / hand / hip / leg / foot

Also travels to: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

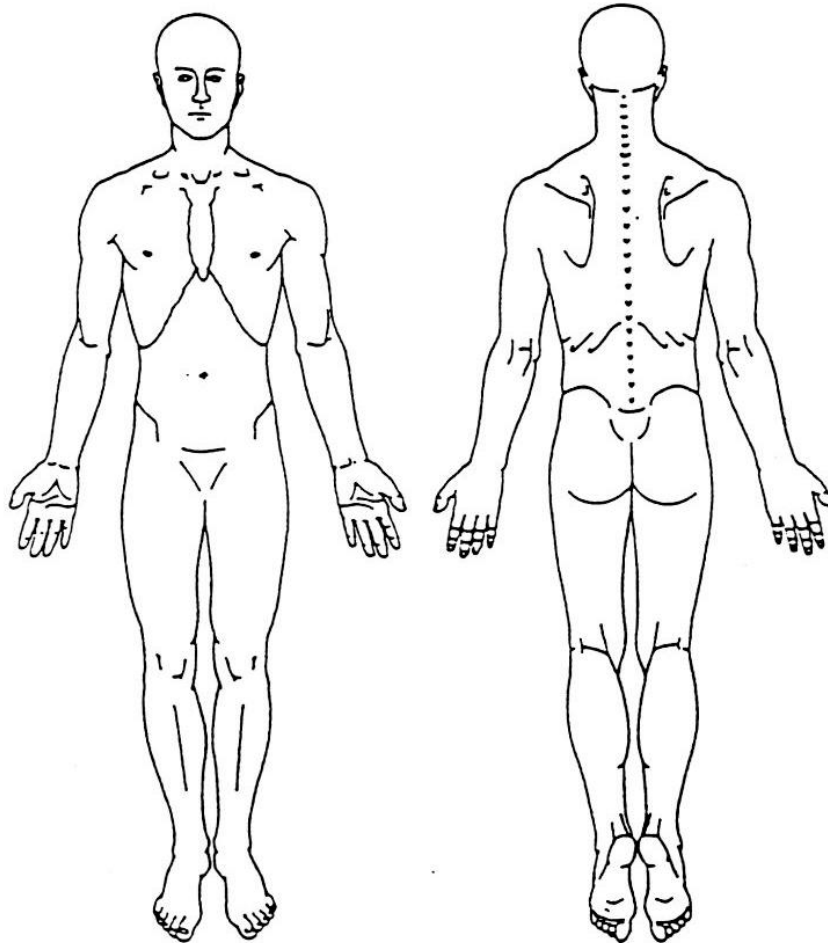
## Body Diagram

### Instructions:

On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition.

Use the letters below to indicate the type and location of your sensation right now

**Key:** A = Ache B = Burning N = Numbness S = Stabbing P = Pins and Needles O = Other



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.

