



Appt Doctor: _____

Appt Date: _____

Appt Time: _____

WELCOMES YOU TO OUR OFFICE

THIS IS A CONFIDENTIAL HEALTH REPORT: PLEASE READ AND COMPLETE BOTH SIDES OF THIS FORM

NAME: _____
First Middle Last

SSN: _____ DATE: _____

ADDRESS: _____

PREFERRED NAME (NICKNAME): _____

CITY: _____

BIRTH DATE: _____ AGE: _____

STATE: _____ ZIP: _____

SEX (circle one): M F

HOME PHONE: _____

MARITAL STATUS (circle one): S M W D

WORK PHONE: _____

NUMBER OF CHILDREN: _____

CELL PHONE: _____

EMERGENCY CONTACT: _____

STUDENT: FT PT SCHOOL: _____

RELATIONSHIP: _____ PHONE: _____

YOUR EMPLOYER: _____

SPOUSE'S NAME: _____

YOUR TYPE OF WORK: _____

SPOUSE'S BIRTH DATE: _____

YOUR E-MAIL ADDRESS: _____

SPOUSE'S EMPLOYER: _____

REFERRED BY: __ATTORNEY __PHYSICIAN __PATIENT __STAFF __LOCATION __MAILING __NEWSPAPER __YELLOW PAGES

SPOUSE'S WORK PHONE: _____

REFERRING PERSON'S NAME: _____

Have you had chiropractic care before? __Yes __No When? _____ Doctor's Name: _____

What are your current complaints? _____

My condition is due to:

- Automobile Accident
- Other Accident
- Work Injury
- Illness
- Unknown Cause

Who is your general practitioner?

Dr. _____

Social habits include use of the following:

- Alcohol
- Tobacco
- Coffee
- Caffeinated beverages

Date symptoms appeared _____

What was the date of your last visit to your general practitioner?

Symptoms are:

- Improving
- About the same
- Getting worse
- Intermittent (come and go)

Other doctors seen for other problems:

Do you exercise?

- Frequently
- Infrequently
- Completely sedentary

Have you had these symptoms before?

- Yes When? _____
- No

List all previous accidents:

Check the following conditions you have or had and circle conditions that are common to other family members:

- Arthritis
- Cardiovascular disease
- Diabetes
- Cancer
- High Blood Pressure

Check any activities which aggravate your condition:

- Standing Lying
- Twisting Walking
- Bending Coughing
- Sitting Lifting

List all previous surgeries:

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD AND CIRCLE CONDITIONS THAT ARE COMMON TO OTHER FAMILY MEMBERS

- Aids Chicken Pox Goiter Mumps Scarlet Fever Ulcers
- Alcoholism Eczema Gout Pacemaker Scoliosis Venereal Disease
- Anemia Emphysema Malaria Pneumonia Stroke
- Appendicitis Epilepsy Measles Polio Tuberculosis
- Arteriosclerosis Foot Problems Multiple Sclerosis Rheumatic Fever Typhoid Fever

CASE HISTORY

DAVIS CHIROPRACTIC

CASE HISTORY (continued) NAME: _____ **Acct:** _____

Please check the appropriate box for any of the following symptoms which you currently have. We need all the facts about your health before we accept your case. **THIS IS A CONFIDENTIAL HEALTH REPORT.**

OCCASIONAL
FREQUENT

- GENERAL**
- Allergies
 - Convulsions
 - Dizziness or fainting
 - Headache
 - Neuralgia
 - Numbness/sensation loss

- MUSCLE & JOINT**
- Arthritis
 - Bursitis
 - Foot trouble
 - Low back pain
 - Neck pain or stiffness
 - Pain between shoulders
 - Sciatica
 - Swollen joints, pain,
 - Shoulder pain
 - Arm pain
 - Elbow pain
 - Hand pain
 - Hip pain
 - Leg pain
 - Knee pain
 - Foot pain

- GASTRO-INTESTINAL**
- Colon trouble
 - Constipation
 - Diarrhea
 - Difficult digestion
 - Distended abdomen
 - Gallbladder trouble
 - Hemorrhoids
 - Liver trouble
 - Pain over stomach
 - Difficult swallowing

- EYES, EARS, NOSE & THROAT**
- Asthma
 - Colds
 - Hearing loss
 - Earaches
 - Ear discharge
 - Ear noises
 - Eye pain
 - Nasal obstruction
 - Nosebleeds
 - Sinus infections
 - Blurred vision
 - Loss of vision

- CARDIO-VASCULAR**
- Hardening of arteries
 - High blood pressure
 - Low blood pressure
 - Pain over heart
 - Poor circulation
 - Rapid heartbeat
 - Slow heartbeat
 - Swelling of ankles
 - Slurred speech
 - Weakness/clumsiness

- RESPIRATORY**
- Chest pain
 - Chronic cough
 - Difficult breathing
 - Spitting up blood
 - Spitting up phlegm
 - Wheezing
- GENITO-URINARY**
- Wheezing
 - Bedwetting
 - Blood in urine
 - Frequent urination

- Incontinence
- Kidney stones/infections
- Painful urination
- Prostate trouble

- SKIN**
- Bruise easily
 - Dryness
 - Rashes
 - Varicose veins

- FOR WOMEN ONLY**
- Congested breasts
 - Lumps in breasts
 - Cramps/backaches
 - Excessive menstrual flow
 - Irregular cycles
 - Painful menstruation
 - Menopausal symptoms
 - Hot flashes
 - Vaginal discharge
- Pregnant?** Yes No
 Date of last period: _____
 Previous miscarriages: _____
 Yes No

INSURANCE INFORMATION

Please fill out the following information regarding your medical insurance. **If information is "same" as that above, please write "same".**

PRIMARY INSURANCE:
 Insurance company name: _____
 Insured's name: _____
 Relationship: Spouse _____ Child _____ Other _____
 Insured's birth date: _____
 Insured's address: _____
 Insured's home phone: _____
 Insured's work phone: _____

SECONDARY INSURANCE:
 Insurance company name: _____
 Insured's name: _____
 Relationship: Spouse _____ Child _____ Other _____
 Insured's birth date: _____
 Insured's address: _____
 Insured's home phone: _____
 Insured's work phone: _____

Other Insurance: _____

AGREEMENTS AND UNDERSTANDINGS

♦ I AGREE THAT FEES ARE PAYABLE WHEN SERVICE IS RECEIVED UNLESS SPECIAL ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. ♦ I hereby give permission to Davis Chiropractic to release any information requested by an insurance company acquired in the course of my examination and treatment. ♦ I hereby authorize and direct my medical benefits to be paid directly to Davis Chiropractic and agree that I am financially responsible for non-covered services or items. ♦ I hereby give permission to Davis Chiropractic to administer treatment and perform such general procedures as the doctor may deem necessary in the diagnosis and/or treatment of my condition. ♦ I hereby certify that I have read and agree to the above statements and that after reading and filling out both sides of this case history, my signature below verifies that all the information I have given is accurate and that I have read the case history questions entirely.

SIGNATURE: _____ **DATE:** _____

CONSENT TO TREATMENT OF A MINOR CHILD: I hereby authorize Davis Chiropractic and its assistants to administer chiropractic care as deemed necessary to my (Indicate relationship of Child): ___daughter ___son ___step-child ___Other: _____

SIGNATURE: _____ **DATE:** _____

(Parent or Legal Guardian)



Financial Policies

You will be expected to pay your patient portion in full on your first visit and once per week thereafter to keep your account current. Patient portion is the amount we **ESTIMATE** that is due from you based upon the benefits quoted to us by your insurance company. Your account will be set up in our computer system so that as each charge for your care and treatment is entered, it will be split to show the estimated percentage due from your insurance company and you. As each payment from your insurance company is entered, your patient portion will be adjusted to reflect any difference between our estimated payment and their actual payment. A statement will be mailed to you at each month-end which will reflect the total balance due on your account, the total amount expected from your insurance company and the total patient portion due from you as of month-end.

Please remember that your insurance contract is between you and your insurance company. We will file your claims weekly and **ESTIMATE** your patient portion as closely as possible. However, you are fully responsible for any and all amounts not paid by your insurance company and you must agree to the following terms and conditions:

- ◆ I authorize payment of all medical benefits directly to Carlton & Harris Chiropractic, Inc. dba Davis Chiropractic.
- ◆ I authorize the release of any medical information necessary in the processing of my insurance claims.
- ◆ I agree that I will pay my patient portion/copay in full on each visit.
- ◆ I understand that if I do not pay my patient portion/copay, my account may be turned over to a collection agency.
- ◆ I agree that I will pay in full all charges for items or services that Davis Chiropractic believes will not be covered by my insurance company at the time they are incurred including, but not limited to: supplies, supports and vitamin/mineral/nutritional supplements.
- ◆ I agree that if my insurance company requests additional information from Davis Chiropractic in order to process my claims, I will pay the additional charge for this service in full immediately including, but not limited to: charges for forms, copies of medical records, narrative medical reports, etc.
- ◆ I agree that if my insurance company does not cover charges within sixty (60) days or a claim is denied, I will pay those charges in full immediately.
- ◆ I agree that if my insurance company refuses to accept assignment of benefits or sends the payments directly to me, I will bring or send those payments to Davis Chiropractic immediately.
- ◆ I agree and understand that Davis Chiropractic will not enter into any dispute with my insurance company regarding a claim and that this is my responsibility and obligation.
- ◆ I agree and understand that **VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT** and that I am personally responsible for payment of any and all charges incurred in this office for my care and treatment.
- ◆ I agree that a photocopy of this document is as valid as the original when used for insurance billing purposes.

My signature below verifies that I have read, fully understand and agree to the above financial policies and will allow Davis Chiropractic to accept my insurance assignment.

INSURED SIGNATURE

DATE

PATIENT SIGNATURE

DATE



ACCOUNT TYPES

Please review the following account types and select the one that most closely applies to you.

_____ **ChiroHealthUSA Discount Program:** Davis Chiropractic participates in the ChiroHealthUSA Discount Network so that we can legally offer discounts to patients who are uninsured or under-insured or with limitations in their health plan such as Medicare and Medicaid patients. ChiroHealthUSA is a contracted network that allows us to set and accept discounts on our services for patients who join the ChiroHealthUSA Program. By joining ChiroHealthUSA, you are entitled to "in-network" discounts that range from 30% up to 50% on all chiropractic care and treatment. Note: Supplies and supplements are not included in the discount program. If you wish to join ChiroHealthUSA, please check this box and one of our staff will be happy to go over the plan with you and enroll you today!

_____ **MAJOR MEDICAL HEALTH INSURANCE:** Select this account type if you want us to bill your health insurance for you. You will be expected to pay in full for services while meeting your deductible (discounts do not apply). After your deductible has been met, you will be responsible for paying for non-covered items at the time of purchase and for the percentage not covered by your health insurance.

_____ **WV WORKERS' COMPENSATION:** Select this account type if you require treatment for an on-the-job injury that occurred in the State of West Virginia. We do not accept out-of-state workers' compensation. The West Virginia Workers' Compensation Fund allows 28 visits for chiropractic treatment over a 60-day period. If further treatment is needed after 28 visits/60 days, we will request authorization from Workers' Compensation. Workers' Compensation typically covers all care and treatment, but they do not cover most supply items such as mineral ice, cold packs, vitamins, etc. You will be required to pay for non-covered items at the time of purchase.

_____ **PERSONAL INJURY:** Select this account type if you require treatment for an injury that occurred in an automobile accident or other injury such as a fall. We will bill your automobile insurance or your health insurance. We do not accept liability insurance (the other party's insurance) because insurance companies only pay at settlement time and will not remit payment to the doctor. We do not accept letters of protection except for a select group of attorneys in this area. If you have retained an attorney, please check with us to see if we will accept his letter of protection.

_____ **MANAGED CARE/HMO/PPO:** We participate with many insurance plans. Some plans such as some United HealthCare (ACN) require pre-authorization before we can begin treatment. Other plans require that you have a referral from your Primary Care Physician before we can begin treatment. It is your responsibility to get the initial referral from your PCP and our responsibility to request authorization for further treatment once the initial treatment has been exhausted. Most plans require that you pay a set dollar amount (copay) on each visit.

_____ **MEDICARE:** Medicare covers chiropractic spinal manipulations. Medicare usually covers manipulations as long as they consider them to be medically necessary. Treatment must be for an acute condition. Medicare does not cover any other treatment, x-rays, exams or supplies. You will be required to pay for non-covered treatment at the time of service and for non-covered supplies at the time of purchase. (Note: Non-covered treatment may be eligible for discounts through the ChiroHealthUSA discount program.)

_____ **MEDICAID:** Only Traditional (indicated by TR on insurance card) West Virginia Medicaid plans cover spinal x-rays and 12 spinal manipulations per fiscal year (July 1 through June 30) and they do not cover any other treatment, exams or supplies. You will be required to pay for non-covered treatment at the time of service and for non-covered supplies at the time of purchase. No other WV Medicaid plans cover chiropractic care. (NOTE: If Medicare is your primary insurance and Medicaid is your secondary, then Medicaid will only cover items approved by Medicare. Therefore, your x-rays will not be covered and your spinal manipulations will only be covered if Medicare approves them for coverage.) (Note: Non-covered treatment may be eligible for discounts through the ChiroHealthUSA discount program.)

My signature below verifies that I have read the above information and selected my account type as indicated. I understand that the above information is summarized to provide a brief overview and is in no way intended to fully explain all the details involved in the various types of insurance plans.

INSURED SIGNATURE

DATE

PATIENT SIGNATURE


DATE

(1) Patient Health Information Consent Form

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 **HIPAA NOTICE** that is available to you at the front desk before signing this consent.

- 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.
- 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.
- A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
- The patient may provide a written request to revoke consent at any time during care. This would not affect 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.
- 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.
- Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
- 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.

 _____


Patient Signature **Date**

(2) HIPAA Compliant Patient Authorization

If you wish for the doctors and/or staff to be able to discuss all aspects of your care and treatment in this office including, but not limited to, your medical condition, your appointments and/or referrals, your account billing and balances due, and your health, personal injury or workers' compensation insurances with another person or persons over the telephone or in person, please list those people below and then sign and date below:

_____	_____
Name	Phone Number
_____	_____
Name	Phone Number
_____	_____
Name	Phone Number

I am authorizing the doctors and staff of Davis Chiropractic to discuss my medical condition with the person or persons listed above.

 _____

Patient Signature **Date**

NOTE: If at any time you wish to revoke the above authorization, the revocation must be provided to us in writing.

(3) Acknowledgement of HIPAA/HITECH Patient Notification of Privacy Practices

Please sign below to certify that you have received, read and understand our Notice of Privacy Practices.

 _____

Patient Signature **Date**

Electronic Health Records Intake Form

First Name: _____ Middle Initial: _____ Last Name: _____

E-mail address: _____ DOB: ____/____/____

Ethnicity (Check One): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> I Decline to Answer	Race (Check One): <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White (Caucasian) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> I Decline to Answer	Smoking Status (Check One): <input type="checkbox"/> Current Every Day Tobacco Smoker <input type="checkbox"/> Current Some Day Tobacco Smoker <input type="checkbox"/> Former Tobacco Smoker <input type="checkbox"/> Heavy Tobacco Smoker <input type="checkbox"/> Light Tobacco Smoker <input type="checkbox"/> Never Smoked Tobacco Smoking Start Date (optional): _____
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	

How do you prefer to be contacted? (check one please)	Phone	E-Mail	Mail/Letter	Fax	Patient Portal

Family Medical History (Record **ONE** specific diagnosis in your family history and the affected person)

Diagnosis (write in below)	Father	Mother	Brother	Sister	Son	Daughter
Example: Diabetes		X				
Example: Hypertension	X					
Example: Breast Cancer				X		

Are you currently taking any medications? Yes (list below) No
 (Please include regularly used over-the-counter medications)

Medication Name (PLEASE PRINT LEGIBLY)	DOSAGE (mg., etc.)	FREQUENCY (i.e.: once daily, twice daily, etc.)

Do you have any medication allergies? Yes (list below) No Known Drug Allergies

Medication Name (PLEASE PRINT LEGIBLY)	Reaction	Onset Date	Additional Comments

I choose to **decline** receipt of my clinical summary after every visit.
 (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

X Patient Signature: _____ Date: _____

For Office use only: Height: _____' _____" Weight: _____ Blood Pressure: _____/_____ Pulse: _____
