Chiropractic Case History/Patient Information

Date: _____ **Name of Primary Health Insurance:** _____

Name: _____ Social Security #_____Home Phone: _____

Address: _____City:_____ State: _____ Zip: _____

E-mail Address: _____ Fax #_____ Cell Phone: _____

Age: _____ Birth Date: _____ Race: _____ Marital: M S W D Gender: M F

Occupation: _____ Employer: _____ Office Phone: _____

Spouse: _____ Birth Date: _____ Employer: _____

How many children? _____ Names and Ages of Children: _____

Name of Nearest Relative: _____ Address: _____Phone:_____

Family Medical Doctor: _____

May we have your permission to update your medical doctor regarding your care at this office? Yes No

How did you hear about our office? _____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____ Is this due to: Auto_____ Work_____ Other_____

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

_____

_____

Days lost from work: _____ Date of last physical examination:_____

List all prescription, over-the-counter medications, and nutritional/herbal supplements you are taking:

_____

Have you ever seen a chiropractor before? Yes No If yes, Name of Dr./Location: _____

Date of last visit: _____ (approx)

Do you have any allergies to any medications? Yes No

If yes, describe: _____

Do you have allergies of any kind?

Family Diseases (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

___ Tuberculosis ___ Cancer ___ Mental Illness ___ Diabetes ___ Asthma
___ Stroke ___ Kidney Disease ___Lung Disease ___ Arthritis ___Liver Disease
___ Heart Disease ___ Other: _____

PAST MEDICAL HISTORY

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Yes No 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, please describe: _____

SOCIAL HISTORY:

Do you drink alcoholic beverages? _____ If so, how much per week? _____
Do you use any tobacco products? _____ Do you smoke? _____ If so, packs per day: _____
Do you consume caffeine? _____ If so, how much per day: _____
What are your hobbies? _____
What % of time during the day (at home or at your job) do you spend: lifting _____ sitting _____ bending _____ in front of the computer _____
What type of regular exercise do you perform? ○ None ○ Light ○ Moderate ○ Strenuous

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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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Patient Health Questionnaire – PHQ

Patient Name_____ **Date** ____ / ____ / ____

1. Describe your symptoms _____

_____

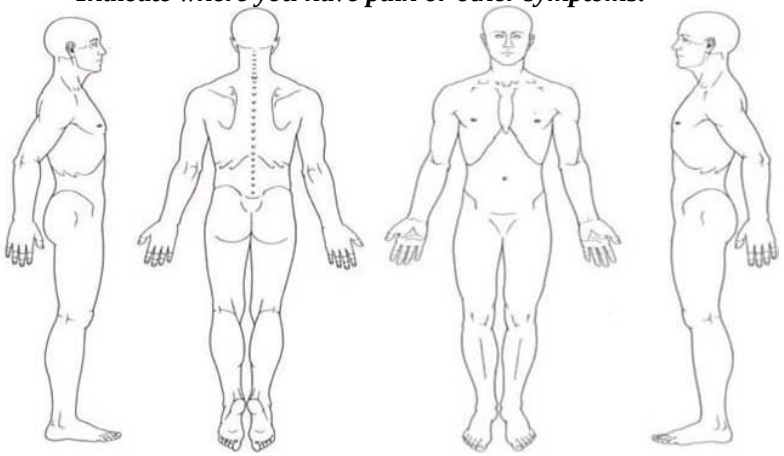
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms:



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting better
② Not changing
③ Getting worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms: None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. For each of the conditions listed below, place a check in the past column if you have had the condition in the past and place a check in the present column if you have the condition presently. Circle L for Left and R for Right where applicable.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Freq. Urination
○	○	Mid Back Pain	○	○	Stroke	○	○	Ruptures
○	○	Low Back Pain	○	○	Angina	○	○	Coughing Blood
			○	○	Kidney Stones	○	○	Eating Disorder
○	○	Shoulder Pain L R	○	○	Kidney Disorders	○	○	Pace Maker
○	○	Elbow/Upper Arm Pain L R	○	○	Bladder Infection	○	○	Allergies
○	○	Wrist Pain L R	○	○	Painful Urination	○	○	Depression
○	○	Hand Pain L R	○	○	Loss of Bladder Control	○	○	Systemic Lupus
			○	○	Prostate Problems	○	○	Epilepsy
○	○	Hip/Upper Leg Pain L R	○	○	Abnormal Weight Gain/Loss	○	○	Dermatitis/Rash
○	○	Knee/Lower Leg Pain L R	○	○	Loss of Appetite	○	○	HIV/AIDS
○	○	Ankle/Foot Pain L R	○	○	Abdominal Pain	○	○	Drug/Alcohol Dependence
○	○	Ulcer	○	○	Osteoarthritis	○	○	Smoking/Use Tobacco Prod.
○	○	Jaw Pain L R	○	○	Hepatitis			
			○	○	Liver/Gall Bladder Disorder			
○	○	Joint Swelling/Stiffness	○	○	Cancer			
○	○	Arthritis	○	○	Tumor	**Females Only**		
○	○	Rheumatoid Arthritis	○	○	Asthma	○	○	Hormonal Rep.
			○	○	Chronic Sinusitis	○	○	Pregnancy
○	○	General Fatigue	○	○	Broken/Fractured Bones	○	○	Birth Control
○	○	Muscular Incoordination	○	○	Circulatory Problems			
○	○	Visual Disturbances	○	○	Seizures/Convulsions	**Other Health Problems**		
○	○	Dizziness	○	○	A Congenital Disease	○	○	
○	○	Numbness/Tingling	○	○	Excessive Bleeding	○	○	

Patient Signature_____ **Date** ____ / ____ / ____

Upper Hand Chiropractic

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.

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 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 in this office.**
4. **The patient may provide written request to revoke consent at any time during care. This would not affect the use of those records for the given prior to the written request to revoke consent but would apply to any care given after the request has been presented.**
5. **For 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 refused 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.

_____

Signature of Patient **Date**

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address;

b. The nature of the treatment;

c. The risks and benefits of that treatment; and

d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with Upper Hand Chiropractic.

Dated this _____ day of _____ 20___

_____ _____

Patient signature (or Legal Guardian) Signature of Witness

Print Name:_____ Print Name:_____

Upper Hand Chiropractic

Phone (315) 303-2243

Dr. Jonathan E. Dehors, DC

Financial Agreement Policy

I agree that in return for the services provided by the doctors at Upper Hand Chiropractic I will pay my account at the time services are rendered or I will make financial arrangements satisfactory to Upper Hand Chiropractic for payment. If my insurance company or health plan designates co-payments, co-insurance and/or deductibles, I agree to pay them to Upper Hand Chiropractic. All service balances are due and payable at the time of service. If payment is not received, we reserve the right to refuse future appointments on delinquent accounts.

No Insurance Coverage: Payment is expected on the day that services are rendered. A fee reduction will be applied to services only if paid in **full** at the time of service and if your account is at a zero balance. We accept cash, check, or credit card.

Insurance: Insurance is a contract between you and your insurance company. You will need to pay your coinsurance and/or co-payments at the time of service. If you choose to pay for all of your treatment in full at time of service, we will promptly issue a refund or credit your account for future care for any credit balance. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the **final determination** of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by them. It is the responsibility of the patient to verify with your insurance company if the provider(s) you are seeing are contracted with the insurance. **If your insurance company requires a referral and/or pre-authorization, it is your responsibility to obtain and provide it to our office.** Failure to obtain the referral and/or pre-authorization may result in a denial from the insurance company, and the balance will be your responsibility.

Medicare: We are a participating provider with Medicare Part B. We agree to bill and accept contractual adjustments from Medicare. There may be services and supplies rendered in our office that are not covered by Medicare and therefore require an Advanced Beneficiary Notice (ABN) be signed by the patient/Guarantor. By signing the ABN, it is understood that you are financially responsible for payment of any services and/or supplies that are not deemed medically necessary by Medicare.

Monthly Statement: If there is a personal patient balance on the account, we will send you a monthly statement. Patients are responsible for all charges resulting from treatment provided at Upper Hand Chiropractic. Payment is due within 30 days of receipt of this statement, unless other financial arrangements have been made with the office manager.

Past Due Accounts: I understand and agree that if my account is delinquent past 90 days without financial arrangement with the office manager, I may be turned over to the collection agency used by Upper Hand Chiropractic.

Returned Checks: There is a fee of $35.00 on any checks returned by the bank due to non-sufficient funds or otherwise.

After Hours Policy: If there is a 'chiropractic emergency' after office hours, there is a $20.00 fee that is payable at the time of service. This fee is not billed or paid by your insurance company if applicable. This fee is in addition to and separate from any chiropractic adjustment fees, co-payments, co-insurance or deductible that you may owe.

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

_____ _____

Patient/Legal Guardian Signature Date

_____

Print Patient Name