

FINN CHIROPRACTIC CENTER

PATIENT INFORMATION

Date: _____

Last Name: _____

First Name: _____ Middle Initial: _____

Sex: Male ___ Female ___ Date of Birth: _____ Age: _____

Home #: _____ Cell #: _____ Work #: _____

Where do you prefer to receive calls? _____

Can we leave a detailed a message on your home phone & cell? () Cell () Home

Can we leave **appointment related info** with anyone answering your phone? _____

Would you like to receive a text appointment reminder? _____

Cell Carrier: _____

Do you give permission for the doctor to text you? _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Phone #: _____

Relationship: Spouse _____ Parent _____ Other _____

Email Address (to receive newsletter): _____

INSURANCE INFORMATION

Primary Policyholder's Name: _____ Date Of Birth: _____

Address (**if different than above**): _____

City: _____ State: _____ Zip: _____

Patient relationship to primary policyholder: self _____ spouse _____ child _____

How did you hear about our office? _____

SYMPTOMS

Reason for visit _____

When did you first notice these symptoms? _____

Is this condition getting progressively worse? _____

Where specifically is the problem (s) located? _____

Which activities are difficult to perform (**please circle**)? Sitting Standing
Walking Bending Lying Down Other

Type of Pain (**please circle**): Dull Sharp Aching Shooting Spasm
Throbbing Burning Numbing Tingling Stiffness Swelling

Rate the severity of your pain (1 is mild pain or discomfort, to 10 is severe pain):

1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition?

Medication ____ Surgery ____ Physical Therapy ____ Other ____

Name of other doctor(s) who have treated you for your condition? _____

List any types of **SURGERIES** which you have had and the dates on which they occurred: _____

Please list all **MEDICATIONS** you are currently taking: _____

Any Allergies: _____

ACCIDENT HISTORY

List all **ACCIDENTS** (cars, sports, etc) _____

List all **BROKEN/FRACTURED** bones and the year it occurred _____

Have you ever been treated by a chiropractor before? If so, when was your last visit? _____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such chiropractic care to a third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ **Date** _____

SIGNATURE OF PATIENT (or parent if patient is a minor)

FINN CHIROPRACTIC CENTER

Consent for Use and Disclosure of Health Information

Date of Consent: _____

Patient Name: _____

Date of Birth: _____

By signing this form, I give this clinic, consent to use and/or disclose my protected health information (PHI) to carry out treatment, payment or health care operations.

I have the right not to sign this consent. If I refuse to sign this consent, this clinic may refuse to not provide me with treatment until I consent.

This clinic has provided me with a copy of its Notice of Privacy Practices which describes how this clinic may use and disclose my health information. I have the right to review this Notice before signing this consent.

This clinic may change the Notice of Privacy Practices as needed. I may obtain a current copy of this clinic's Notice of Privacy Practices by contacting this clinic's Privacy Officer.

I have the right to withdraw this consent at any time. I must do this in writing to this clinic. Note that my withdrawal of this consent will *not* be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then this clinic, by law, is unable to provide to me further treatment or follow-up, other than required emergency services.

This consent is good unless and until I withdraw it in writing.

Signature of Patient or Legal Representative

Date

FINN CHIROPRACTIC CENTER

Acknowledgment of Notice of Privacy Practices

I acknowledge that a copy of this clinic's Notice of Privacy Practice's has been made available to me. I also understand that this Notice is available by request.

Name of Patient or Legal Representative

Date

Signature of Patient or Legal Representative

Date

INSURANCE ASSIGNMENT POLICY STATEMENT

Dear Patient:

You have selected "INSURANCE ASSIGNMENT" as the method of choice to take care of your financial obligation with this office.

It is important that you realize that in this office we offer the option of "INSURANCE ASSIGNMENT" strictly as a courtesy to our patients, and as a result, patients must understand and agree to the following:

1. That you are considered a "cash" patient until you bring in a current insurance card and this office qualifies and accepts your coverage.
2. That you are ultimately responsible for full payment of any and all services rendered.
3. That you must pay all deductibles in full.
4. That co-insurance and co-pays must be paid at the time of service, or at the end of each week if you are coming several times a week. You may pay with cash, check or credit card (except American Express). We also accept HRA Spending Account credit cards.
5. That if your carrier has not paid a claim within 60 days of submission, you are responsible for taking an active part in the recovery for your claim, and that after 90 days you will be responsible for payment in full of any outstanding balance.
6. If you have an outstanding balance on your account, we will bill you via mail. Any bills not paid within 60 days are subject to a \$10 late fee. Any bills not paid within 90 days will be forwarded to a collection agency.

This insurance assignment policy must be followed, and we ask that you sign this form as acknowledgement that our policy was explained to you, that you understand it, and you accept full responsibility.

Date: _____

Patient's Name: _____

Patient's Signature: _____

Witness: _____

CONSENT TO TREATMENT OF A MINOR

I hereby request and authorize Dr. **Jennifer Finn**, to administer chiropractic care as she deems necessary to my dependent minor child.

Child's Name: _____ Your Relationship to Child: _____

As of today's date, I have the legal right to select and authorize health care service for the minor child named above. If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office. I understand that if I am a legal guardian, I may be asked to provide proof of guardianship prior to treatment being rendered.

Date

Phone

Parent/Guardian Signature

Parent/Guardian Printed Name

Special Instructions:

This facility follows state guidelines regarding the treatment of minors. This state permits a minor to present for treatment without parent/guardian attendance, only with the consent of a parent/guardian.

List the name and relationship of individual(s) that may also bring my child in for care: (grandparents, older siblings, etc)

_____ Name	_____ Relationship	_____ Name	_____ Relationship
_____ Name	_____ Relationship	_____ Name	_____ Relationship

In some instances, older minor children may present for care without a parent or other representation. This occurs commonly with students of driving age. Though it is required that a parent/guardian make the appointment for the minor, this facility must have permission to present for care at the scheduled appointment time without the responsible party (parent/guardian) present. By office policy, in this event, any treatment outside of what would be considered routine, the responsible party (parent/guardian) will be contacted and notified prior to the rendering of such service(s).

By signing below, I authorize my minor child to present for treatment without a parent/guardian present. I understand that myself or another parent/guardian are responsible for scheduling the minor child's appointment so as to confirm that I am aware the child is being treated.

I understand that I may make changes to this consent at any time, and to update or change the terms of this agreement, it is my responsibility to notify the front desk and request an updated consent form.

Parent/Guardian Signature

Date

**Consent for Use and Disclosure of Health Information to
Family, Friends and Others Involved in Your Care**

Patient Name: _____

Date of Birth: _____ Date of Consent: _____

By signing this form, I give **FINN CHIROPRACTIC CENTER** consent to use and/or disclose my protected health information (PHI) to my family, close friends, or others involved in my care and/or payment of my care pertaining to health information and treatment, appointments, and financial agreements. Please list the names and relationship of those individuals you would like us to share information with, as well as any restrictions.

Name	Relationship	Restrictions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have the right to withdraw this consent at any time. I must do this in writing to **Finn Chiropractic Center**. This consent is good unless and until I withdraw it in writing.

Signature of Patient or Legal Representative *Date*