Murphy Chiropractic & Wellness, P.A.
Dr. Jerry Murphy, D.C.
1114 S. Long Drive
Rockingham, NC 28379
Phone: 910-817-7126
Fax: 910-817-7013

What to Expect

We want to thank you for choosing Murphy Chiropractic & Wellness to be a part of your healthcare team. Chiropractic care is not a "one and done" appointment, though we do see numerous patient's that feel much better after their first adjustment. Your treatment plan is specific to you and it is important that you do not miss your appointments. You will notice at the beginning of your treatment that you may be scheduled to come 2-3 times a week. You are being seen more frequently at the beginning because we are working to change your body's "bad habits." Your first adjustment may only last a few hours and each adjustment builds upon the one prior and in time your body will naturally begin to "hold" the adjustment for longer periods of time. When we see you reaching this point in your treatment, we will re-evaluate you and hopefully begin to transition you to wellness visits when you may come once a month!

Appointments

Our chiropractic appointments are scheduled every 15 minutes throughout the day and massage appointments can range from 30 minutes to an hour and a half. We make reminder phone calls daily for all appointments for the following day. Many times when we can't reach you by phone we are unable to leave a voicemail due to your mailbox being full or not being set up. We encourage all patients to please make sure your voicemail is set up, and please check your messages as it may be an appointment reminder.

Because we dedicate time to make these reminder calls, we have instated a missed/no show appointment policy. We require at least 24 hours' notice of cancellation or rescheduling. Failure to do so will result in a missed/no-show appointment fee. **This fee is not covered by insurance and will be your responsibility.** Forgetting your appointment, over-sleeping, or last-minute work or social obligations are not considered emergencies, so a missed/no-show appointment fee will be charged to you in those circumstances.

Also, if you to additional time with Dr. Murphy beyond a regular adjustment appointment, we ask that you let us know in advance so we can schedule you for a consultation in order to provide the extra time needed to discuss any questions, concerns or new complaints/areas of pain that you may have. We value your time and ours and are striving daily to keep your wait times as minimal as possible.

Late for your appointment

If you are more than 15 (fifteen) minutes late for your appointment you may not be treated or you may receive an abbreviated treatment within the time constraints of your originally scheduled appointment.

Reschedule/Cancellation Policy

In order to be respectful of other patient's needs, please be courteous and call us promptly if you are unable to show up for your appointment. We are a "high volume" office and appointments are in high demand. Your early cancellation or rescheduled appointment will be reallocated to someone who may be waiting for an appointment time to open.

If you need to reschedule or cancel an appointment, please do so at least 24 hours in advance. If you call after regular business hours, please leave us a voicemail.

If you reschedule or cancel your appointment on the **same day**, you will be charged a fee for your appointment. If you are scheduled for a massage appointment, and we do not receive confirmation by 5:00 pm the day before your appointment, your appointment may be rescheduled to a later date.

Chiropractic - $15 fee **Massage** - $25 fee

Missed Appointment/No-Show

If you miss an appointment without calling to notify the office at least 24 hours in advance you will be charged the fee(s) as listed above.

If you miss 3 or more consecutive appointments, you may be transitioned to a once a month wellness patient.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Murphy Chiropractic & Wellness, P.A.
Dr. Jerry Murphy, D.C.
1114 S. Long Drive
Rockingham, NC 28379
Phone: 910-817-7126
Fax: 910-817-7013

Auto-Accident Form (PI)

Date

First Name
Last Name
DOB
Sex ◯ Male ◯ Female
SSN XXX—XX— _____
Address
City
State
Zip Code

Phone 1
◯ Home ◯ Mobile ◯ Work ◯ Other
Phone 2
◯ Home ◯ Mobile ◯ Work ◯ Other
Fax
Email
Employer
Employer Phone
Occupation

Job Status
◯ Not Employed ◯ Employed
◯ Part-Time Student ◯ Retired
◯ Full-Time Student

Marital Status
◯ Single ◯ Married ◯ Other

Receive Appointment Reminders
◯ Declined ◯ Voice ◯ Text ◯ Email

Height ' "
Weight lbs

Reason For Visit: ◯ New Patient ◯ Adjustment ◯ Physical ◯ Consultation ◯ X-Rays ◯ Therapy ◯ Injury
◯ Report of Findings ◯ Auto Accident ◯ Re-Examination ◯ Other

Referred By: ◯ Provider ◯ Friend ◯ Family ◯ Other
Referred By Name

How Heard of Us: ◯ Walk in ◯ Referral ◯ Phone Book ◯ Website
◯ Advertisement ◯ Other

Demographics

Race: ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Asian
◯ Native Hawaiian or Other Specific Islander ◯ Other

Ethnicity: ◯ Hispanic or Latino ◯ Non- Hispanic or Latino ◯ Unknown ◯ Other

Dominance: ◯ Right ◯ Left ◯ Ambidextrous

Emergency Contact Information

First Name
Last Name
Relationship
Phone 1
Phone 2

Daily Habits

Do you smoke? ◯ Never smoked ◯ Unknown if ever smoked ◯ Unknown if currently smokes
◯ Current every day smoker ◯ Current some day smoker ◯ Former smoker
If yes, how many packs per day? How many years?

Daily Caffeinated Beverages: ◯ Unknown ◯ None ◯ 1 to 3 ◯ 4 to 6 ◯ 7 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ 21 to 25 ◯ Over 25

Weekly Alcoholic Drinks: ◯ Unknown ◯ None ◯ 1 to 3 ◯ 4 to 6 ◯ 7 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ 21 to 25 ◯ Over 25

Do you exercise regularly? ◯ no ◯ light ◯ moderate ◯ heavy

Health History

Medications/Vitamins/Supplements:

Surgeries:

Traumas:

Allergies:

Illnesses: Please check all that apply

☐ AIDS/HIV	☐ Chronic Fatigue	☐ Heart Disease	☐ Miscarriage	☐ Seizures
☐ Anemia	☐ Depression	☐ Hepatitis	☐ Multiple Sclerosis	☐ Stroke
☐ Arthritis	☐ Diabetes	☐ Hernia	☐ Osteoporosis	☐ Suicide Attempt
☐ Asthma	☐ Emphysema	☐ Herniated Disc	☐ Pacemaker	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Epilepsy	☐ High Blood Pressure	☐ Parkinson's Disease	☐ Tuberculosis
☐ Breast Lump	☐ Fibromyalgia	☐ High Cholesterol	☐ Pinched Nerve	☐ Tumors/Growths
☐ Bronchitis	☐ Fractures	☐ Immune Deficiency	☐ Prostate Problems	☐ Ulcers
☐ Cancer	☐ Gallstones	☐ Kidney Disease	☐ Prosthesis	☐ Vaginal Infections
☐ Chemical Dependency	☐ Glaucoma	☐ Liver Disease	☐ Psychiatric Disorder	☐ Venereal Disease
☐ Chicken Pox	☐ Gout	☐ Migraine Headaches	☐ Rheumatoid Arthritis	☐ Whooping Cough

☐ Other _____

Is there any history in your family for any of the above conditions?

Who? _____

What did they have? _____

Energy Level: ○ Good ○ Insufficient ○ Erratic

Sleep: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful ☐ Other _____

Stress: ○ None ○ Low ○ Moderate ○ Severe What causes stress? _____

Have you had unexpected weight loss in the last 6 months? ○ Yes ○ No If yes, how much? _____

Accident History

When did the accident occur? _____ days ago _____ weeks ago **Date of Accident:** _____

Where were you located at the time of the accident? ◯ driver ◯ front passenger ◯ rear passenger ◯ pedestrian

If you were not the driver, please write the first/last name and city/state of the driver in the box below.

How many people, including the driver, were in the vehicle at the time of the accident?

Have you retained an attorney? ◯ yes ◯ no

If yes, please write the attorney's name, location, and phone number in the box below.

Who was the driver of the other vehicle? Please write their name and city/state in the box below.

Did anyone witness the accident? ◯ no ◯ one person ◯ two people ◯ three people ◯ several people

Where did the accident occur? ◯ at an intersection ◯ in a parking lot ◯ in town ◯ on the interstate ◯ on a highway ◯ other _____

What is the make and model of your vehicle? _____

How many vehicles were involved in the accident? _____

What direction were you headed? ◯ north ◯ east ◯ south ◯ west

How fast was the vehicle going at time of impact? _____ mph

At impact, was the vehicle stopped, slowing down or speeding up? ◯ stopped ◯ slowing down ◯ speeding up

Was the other vehicle stopped, slowing down or speeding up? ◯ stopped ◯ slowing down ◯ speeding up

What time of day did the accident occur? ◯ morning ◯ afternoon ◯ evening ◯ night

How were the driving conditions at the time of the accident? ☐ normal ☐ dry ☐ icy ☐ stormy ☐ wet ☐ windy

What type of impact occurred? ☐ side-driver's ☐ side-passenger's ☐ front ☐ rear

Did the vehicle hit another structure after the accident? ☐ did not ☐ building ☐ ditch ☐ fire hydrant ☐ median ☐ pole ☐ railing ☐ second vehicle ☐ tree ☐ other _____

Did any part of your body strike anything in the vehicle? ☐ face ☐ jaw ☐ neck ☐ shoulders ☐ elbows ☐ chest ☐ hips ☐ legs ☐ shins ☐ knees ☐ feet ☐ other _____

Where were you looking at the time of impact? ◯ straight ahead ◯ to the left ◯ to the right ◯ up ◯ down

Which hands were on the steering wheel? ◯ none ◯ both hands ◯ left hand ◯ right hand

Which foot was on the brake? ◯ both ◯ neither ◯ left foot ◯ right foot

Which position was the headrest in? ◯ vehicle did not have a headrest ◯ low ◯ in mid-position ◯ high

What air bags deployed? ☐ no air bags deployed ☐ steering wheel air bag ☐ driver's side air bag ☐ passenger's side air bag

Were you wearing a seatbelt? ◯ yes ◯ no

What doors would not open as a result of the accident? ☐ all doors freely opened after accident ☐ front left ☐ front right ☐ rear left ☐ rear right ☐ other _____

Did you go to hospital? ◯ yes ◯ no

Hospital Information

Hospital Name _____ Hospital Location _____

Were you hospitalized overnight? ○ yes ○ no

Were you prescribed anything? ☐ arm brace ☐ crutches ☐ knee brace ☐ leg brace ☐ muscle relaxers
☐ neck brace ☐ pain medication ☐ topical analgesic ☐ wrist brace ☐ other _____

What services were performed at the hospital? ☐ none ☐ evaluation by a medical doctor ☐ X-rays ☐ MRI ☐ CT scan
☐ cast ☐ emergency life saving procedures ☐ blood transfusion ☐ stitches ☐ other _____

What types of diagnostic tests have been performed? ☐ amniocentesis ☐ basic metabolic panel ☐ biopsy ☐ CAT scan
☐ celiac profile ☐ colonoscopy ☐ complete blood count ☐ complete blood count with differential
☐ comprehensive metabolic panel ☐ diagnostic ultrasound ☐ echocardiogram ☐ electrolyte panel ☐ endoscopy
☐ extended cardiac risk profile ☐ hepatic function panel ☐ hepatitis panel, acute ☐ hepatitis panel, chronic
☐ lipid panel ☐ mammogram ☐ MRI ☐ OB profile ☐ PET scan ☐ renal panel ☐ urinalysis ☐ X-ray or X-ray series

Have you received X-rays for this accident? ○ yes ○ no

If yes, which areas were X-rayed? ☐ skull (head) ☐ cervical (neck) ☐ thoracic (mid back) ☐ ribs ☐ lumbar (low back)
☐ sacral/pelvis ☐ chest ☐ abdomen ☐ left shoulder ☐ right shoulder ☐ left elbow ☐ right elbow
☐ left wrist ☐ right wrist ☐ left hand ☐ right hand ☐ left hip ☐ right hip ☐ left upper leg ☐ right upper leg
☐ left knee ☐ right knee ☐ left lower leg ☐ right lower leg ☐ left ankle ☐ right ankle ☐ left foot ☐ right foot

Condition

What treatments have you received since the accident? ☐ ice ☐ heat ☐ oral pain medication ☐ topical analgesics
☐ muscle relaxers ☐ wrist brace ☐ knee brace ☐ neck brace ☐ ankle brace ☐ crutches ☐ other _____

How often have you been receiving treatment? ☐ daily ☐ twice per week ☐ three times per week
☐ four times per week ☐ five times per week ☐ weekly ☐ bi-weekly ☐ monthly

Details of treatment received

Location and provider where previous treatment was received

Are you responding to treatment? ☐ the same ☐ improving ☐ worse ☐ other _____

How did you feel immediately following the accident? ☐ head pain ☐ neck pain ☐ neck stiffness ☐ jaw/facial pain (TMJ)
☐ shoulder pain ☐ shoulder stiffness ☐ arm pain ☐ chest pain ☐ back pain ☐ low back pain ☐ lower limb pain
☐ back stiffness ☐ ear buzzing/ringing in the ears ☐ feet/toe numbness or tingling ☐ hands/fingers numbness or tingling
☐ upper limb numbness or tingling ☐ cold feet ☐ cold hands ☐ cold sweats ☐ constipation ☐ anxiety
☐ depression ☐ diarrhea ☐ difficulty swallowing ☐ dizzy/dazed ☐ disoriented ☐ fainting ☐ fatigue
☐ forgetfulness ☐ impaired concentration ☐ irritability ☐ sensitivity to light ☐ sensitivity to noise ☐ loss of balance
☐ loss of smell ☐ loss of taste ☐ loss of memory ☐ muscle spasms ☐ nauseous ☐ nervousness ☐ pins and needles
☐ restlessness ☐ shortness of breath ☐ sleeping problems ☐ stomach upset ☐ tension ☐ vision blurred ☐ weakness

What symptoms did you experience since the accident? ☐ head pain ☐ neck pain ☐ neck stiffness
☐ jaw/facial pain (TMJ) ☐ shoulder pain ☐ shoulder stiffness ☐ arm pain ☐ chest pain ☐ back pain ☐ low back pain
☐ lower limb pain ☐ back stiffness ☐ ear buzzing/ringing in the ears ☐ feet/toe numbness or tingling
☐ hands/fingers numbness or tingling ☐ upper limb numbness or tingling ☐ cold feet ☐ cold hands ☐ cold sweats
☐ constipation ☐ anxiety ☐ depression ☐ diarrhea ☐ difficulty swallowing ☐ dizzy/dazed ☐ disoriented
☐ fainting ☐ fatigue ☐ forgetfulness ☐ impaired concentration ☐ irritability ☐ sensitivity to light
☐ sensitivity to noise ☐ loss of balance ☐ loss of smell ☐ loss of taste ☐ loss of memory ☐ muscle spasms
☐ nauseous ☐ nervousness ☐ pins and needles ☐ restlessness ☐ shortness of breath ☐ sleeping problems
☐ stomach upset ☐ tension ☐ vision blurred ☐ weakness

Describe the pain? ☐ aching ☐ burning ☐ cramping ☐ deep ☐ dull ☐ numb ☐ radiating ☐ sharp
☐ shooting ☐ stabbing ☐ stiff ☐ swelling ☐ tight ☐ tingling ☐ throbbing

Does the pain travel anywhere else? ☐ denies radiating pain ☐ TMJ ☐ left TMJ ☐ right TMJ ☐ cranium (headache)
☐ left cranium (headache) ☐ right cranium (headache) ☐ cervical ☐ left upper cervical ☐ right upper cervical
☐ left lower cervical ☐ right lower cervical ☐ upper thoracic ☐ left upper thoracic ☐ right upper thoracic
☐ mid thoracic ☐ left mid thoracic ☐ right mid thoracic ☐ lower thoracic ☐ left lower thoracic ☐ right lower thoracic
☐ anterior rib ☐ left anterior rib ☐ right anterior rib ☐ posterior rib ☐ left posterior rib ☐ right posterior rib
☐ upper lumbar ☐ left upper lumbar ☐ right upper lumbar ☐ lower lumbar ☐ left lower lumbar ☐ right lower lumbar
☐ lumbosacral ☐ right lumbosacral ☐ left lumbosacral ☐ right sacroiliac ☐ left sacroiliac ☐ left anterior shoulder
☐ right anterior shoulder ☐ left posterior shoulder ☐ right posterior shoulder ☐ right arm ☐ left arm ☐ right elbow
☐ left elbow ☐ right forearm ☐ left forearm ☐ right wrist ☐ left wrist ☐ right hand ☐ left hand ☐ right hip
☐ left hip ☐ right leg ☐ left leg ☐ right thigh ☐ left thigh ☐ right knee ☐ left knee ☐ right calf
☐ left calf ☐ right ankle ☐ left ankle ☐ right foot ☐ left foot

Rate your pain on a scale of 0 to 10. *0 being no pain at all and 10 being the worst pain imagineable*
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

How many days of work have you missed as a result of this accident? _____

Aggravating Factors: What makes the problem worse? ☐ nothing ☐ most movements ☐ bending ☐ carrying things
☐ coughing ☐ driving ☐ eating ☐ exercise ☐ going down stairs ☐ going from lying to sitting
☐ going from lying to standing ☐ going from sitting to standing ☐ heat ☐ housework ☐ ice ☐ jogging ☐ lifting
☐ lying down ☐ massage ☐ pulling ☐ pushing ☐ running ☐ sitting ☐ sleeping ☐ sneezing ☐ squatting
☐ standing ☐ standing for a long period of time ☐ stress ☐ stretching ☐ taking a deep breath ☐ turning
☐ twisting ☐ walking ☐ working

Relieving Factors: What makes the problem better? ☐ nothing ☐ anti-inflammatories ☐ bracing ☐ chiropractic care
☐ elevation ☐ exercise ☐ heat ☐ ice ☐ massage ☐ movement ☐ pain killers ☐ rest ☐ stretching
☐ walking ☐ wraps

What daily activities are affected due to the problem? ☐ bathing ☐ caring for children ☐ cleaning ☐ climbing stairs
☐ cooking ☐ doing laundry ☐ dressing ☐ driving ☐ eating ☐ exercising ☐ **going from laying down to sitting**
☐ going from sitting to standing ☐ grooming ☐ house work ☐ laying down ☐ lifting ☐ oral care ☐ sex
☐ shopping ☐ sitting ☐ sleeping ☐ social/recreational activities ☐ standing ☐ stretching ☐ toileting
☐ transferring ☐ using technology ☐ using phone ☐ walking ☐ watching tv ☐ working ☐ yard work

Review of Systems

Musculoskeletal: Please check all that apply ☐ None

☐ Arm/hand pain ☐ back pain ☐ Feet/leg pain ☐ hip ☐ Knee ☐ Lower back pain ☐ Mid back pain ☐ Muscle or joint pain

☐ Neck pain ☐ Redness of joints ☐ Shoulder(s) pain ☐ Stiffness ☐ Swelling of joints ☐ Upper back pain

Cardiovascular/Respiratory: Please check all that apply ☐ None

☐ Chest pain, pressure or discomfort ☐ Cold hands/feet ☐ Coughing up blood (hemoptysis) ☐ Coughing up phlegm ☐ Persistent Coughing

☐ Difficulty breathing ☐ Dizziness/lightheaded ☐ Fainting ☐ Irregular heartbeat ☐ Palpitations

☐ Shortness of breath ☐ Sudden awakening with a shortness of breath (paroxysmal nocturnal dyspnea)

☐ Swelling (edema) ☐ Tightness in chest ☐ Wheezing ☐ Other _____

Head/Neck: Please check all that apply ☐ None

☐ Dizziness ☐ Facial pain ☐ Grinding Teeth ☐ Headache ☐ Head injury ☐ Hoarseness ☐ Jaw Clicks ☐ Lumps

☐ Migraines ☐ Pain ☐ Sore throat ☐ Stiffness ☐ Swollen Glands ☐ Tooth problems ☐ Trouble swallowing

☐ Other _____

Eyes: Please check all that apply ☐ None

☐ Blurred Vision ☐ Burning ☐ Cataracts ☐ Double vision ☐ Dryness ☐ Flashing lights ☐ Glasses/Contacts ☐ Glaucoma

☐ Itching ☐ Pain ☐ Redness ☐ Specks ☐ Vision Problems ☐ Other _____

Ears: Please check all that apply ☐ None

☐ Buzzing in ears ☐ Decreased hearing ☐ Drainage ☐ Earache ☐ Ear infections ☐ Poor balance ☐ Poor hearing

☐ Ringing in ears (tinnitus) ☐ Other _____

Nose: Please check all that apply ☐ None

☐ Allergies ☐ Blocked Sinuses ☐ Discharge ☐ Excessive mucus ☐ Hay fever ☐ Itching ☐ Nose bleeds

☐ Sinus pressure/pain ☐ Stuffiness/blockage ☐ Other _____

Throat/Mouth: Please check all that apply ☐ None

☐ Bleeding ☐ Blue lips ☐ Braces ☐ Dentures ☐ Difficulty swallowing ☐ Dry mouth ☐ Hoarseness

☐ Mouth pain ☐ Non healing sores ☐ Redness ☐ Sore throat ☐ Sores on lips or tongue ☐ Swelling

☐ Thrush ☐ Tooth pain ☐ Other _____

Urinary: Please check all that apply ☐ None

☐ Blood in urine (hematuria) ☐ Burning or pain ☐ Difficulty urinating ☐ Frequent urinary tract infections

☐ Frequent urination ☐ Incontinence ☐ Kidney infections ☐ Kidney stones ☐ Unable to hold urine (incontinence)

☐ Up at night to urinate ☐ Urgency ☐ Water retention ☐ Other _____

Gastrointestinal: Please check all that apply ☐ None

☐ Change in appetite ☐ Change in bowel habits ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Nausea

☐ Rectal bleeding ☐ Swallowing difficulties ☐ Yellow eyes or skin (jaundice) ☐ Other _____

Endocrine: Please check all that apply ☐ None

☐ Change in appetite ☐ Cold intolerance ☐ Constipation ☐ Diarrhea ☐ Dry skin ☐ Excessive thirst

☐ Frequent urination ☐ Heat intolerence ☐ Sweating

Review of Systems

Vascular/Hematologic: Please check all that apply ☐ None

☐ Calf pain with walking (claudication) ☐ Cold hands and feet ☐ Ease of bleeding ☐ Ease of bruising ☐ Leg cramping

Neurologic: Please check all that apply ☐ None

☐ Dizziness ☐ Easily angered/irritated ☐ Fainting ☐ Frequent crying ☐ Memory confusion ☐ Nervousness ☐ Neuralgia

☐ Numbness ☐ Poor concentration ☐ Seizures ☐ Suicidal thoughts ☐ Tingling ☐ Tremors ☐ Weakness

☐ Worry/anxiety ☐ Other _____

Psychiatric: Please check all that apply ☐ None

☐ Anxiety ☐ Depression ☐ Memory loss ☐ Nervousness ☐ Stress ☐ Other _____

Female:

Are you pregnant? ○ Yes ○ No Date of last period _____ Number of days between periods _____

Age started _____ Age stopped _____

Number of pregnancies _____ Number of deliveries _____ Number of miscarriages _____

Number of abortions _____ Number of Cesareans _____ Operations ☐ Cervix ☐ Uterus ☐ Ovaries

Please check all that apply ☐ None

☐ Clotting ☐ Dark color ☐ Discharge ☐ Food cravings ☐ Heavy bleeding ☐ Hot flashes ☐ Infections

☐ Irregular periods ☐ Itching or rash ☐ Leg cramps ☐ Light bleeding ☐ Little/no sex drive ☐ Menstrual pain/cramps

☐ Missed periods ☐ Mood swings ☐ Painful breasts ☐ Pain with sex ☐ STD's ☐ Vaginal discharge

☐ Vaginal dryness ☐ Vaginal sores ☐ Water retention ☐ Other _____

Acknowledgment of Non-Pregnancy Status

I hereby expressly acknowledge that I am not pregnant at the present time and that Dr. Murphy and Murphy Chiropractic and Wellness, P.A., is hereby expressly authorized and directed to complete a radiographic examination (X-rays) in connection with my chiropractic treatment.

_____ _____/_____/_____

Patient's Signature Date

Male: Please check all that apply ☐ None

☐ Discharges ☐ Erectile dysfunction ☐ Hernia ☐ Impotence ☐ Low sex drive ☐ Masses or pain ☐ Painful urination

☐ Pain with sex ☐ Painful discharge ☐ Prostate problems ☐ Sores ☐ STD's ☐ Other _____

ASSIGNMENT OF INSURANCE BENEFIS

_____ _____/_____/_____
Patient's Name Patient's Date of Birth

_____ _____/_____/_____
Insured's Name Insured's Date of Birth

I authorize and direct that payment be made directly to:

Murphy Chiropractic and Wellness, P.A., 1114 S Long Drive, Rockingham, NC 28379

For any and all insurance benefits or reimbursement for services rendered by Murphy Chiropractic and Wellness, PA which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

Release of Information

By signing below, I authorize the release of any information concerning my health and health care services to my insurance companies, other health care professionals, or hospitals when necessary for diagnosis, assessment, or treatment of my health condition. I also authorize the release of any health information and billing records to another party if they are potentially responsible for payment of my services.

Payment Agreement

I understand that there is no guarantee that my insurance companies or my pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges. I also understand that if my account becomes delinquent, Murphy Chiropractic and Wellness, PA will utilize the services of a collection agency. If this action is needed, I will be responsible for any additional fees accumulated to collect my outstanding balance.

Consent to Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. In do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the facts then known to him or her, is in my best interest.

I have read, or have read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

HIPAA Privacy Practices

I acknowledge that I have received and/or have been given the opportunity to review this Chiropractic Office's Notice of HIPPA Privacy Practices for protected health information.

Consent of Treatment of a Minor

I hereby authorize Dr. Murphy and Murphy Chiropractic and Wellness, P.A., together with whomever my treating doctor may designate as an appropriate individual(s) to administer chiropractic care, including X-rays, and appropriate adjunctive services as my treating chiropractor deems is necessary to my child. I acknowledge that I have legal authority to provide such written consent on behalf of such child/ward.

_____
Patient Name

_____ _____/_____/_____
Patient or Legal Guardian Signature ***Date***

AUTHORIZATION OF ASSIGNMENT AND LIEN

I hereby authorize and direct any and all insurance carriers, attorneys, and/or other legal entities which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future to pay directly and exclusively in the name of Murphy Chiropractic and Wellness, PA such sums as may be owing to Murphy Chiropractic and Wellness, PA for charges incurred by me at the office relating to my condition.

I further grant a lien to Murphy Chiropractic and Wellness, PA with respect to my charges. This lien should apply to all payers and to the full extent permitted by law. For the purposes of this document benefits shall include, but not be limited to proceeds for any settlement, judgment, or verdict as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payment benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation and any other benefits or proceeds payable to me for the purposes stated herein.

In the event that I retain one or more attorneys to represent me in this matter who are not located in North Carolina; I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed consent of this office.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers to facilitate collection under this Assignment and Lien.

I further authorize and direct all payers to release to Murphy Chiropractic and Wellness, PA any information regarding any coverage or benefit which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

I hereby direct this office to file a copy of this Assignment and Lien, together with any applicable charges, with any and all payers, regardless of whether a claim has been established with said payers.

I hereby authorize Murphy Chiropractic and Wellness, PA to endorse/sign my name on any and all checks listing me as a payee, which are presented to this office for payment of an account relating to me. I further authorize Murphy Chiropractic and Wellness, PA to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me.

I hereby authorize and direct my attorney to disclose upon the request of Murphy Chiropractic and Wellness, PA, any settlement amounts or any offers made on my case from any potential payers.

I understand that I may remain personally responsible for the total amounts due to Murphy Chiropractic and Wellness, PA for their services. This Assignment and Lien does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Murphy Chiropractic and Wellness, PA for all costs of such collection efforts, including but not limited to all court costs and attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of Murphy Chiropractic and Wellness, PA and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

Patient Name (please print):_____ Date: _____/_____/_____

Patient Signature:_____

If patient is under the age of 18:

Name of Custodial Parent or Legal Guardian (please print):_____

Parent/Guardian Signature:_____

MEDPAY OFFICE POLICY

Personal Injury cases are accepted in our office. All personal injury cases, whether car or home accidents, must provide necessary information regarding your personal car insurance, the "at fault" insurance, your commercial health insurance, as well as the accident report, and attorney name and contact information if one has been retained.
The personal car insurance is needed because most individuals have medical benefits (usually called "Medpay" or" PIP") included in their automobile policies and some do not even realize it. If these benefits are available on your policy, our office requires that you use them in the event that your injuries are as a result of an automobile accident.
The following outlines why we require Medpay or PIP be filed:

1. **Medpay and PIP are exactly like health insurance – using either form of coverage does not cause your rates to go up**. However, if your rates are increased it is not because of the medpay was filed. It is most likely because: (a) the accident was determined by the insurance company to be your fault, (b) you received a police citation or ticket, and (c) you have been involved in numerous reported auto accidents within a brief period of time and are therefore considered "high risk".

2. **Filing your Medpay or PIP does not relieve the "at Fault" party from having to pay in full for your loss.** Filing Medpay or PIP does not relieve the other party from being held responsible for payment. If the "at fault" driver's liability insurance refuses to make payment on your medical bills for whatever reason, filing your Medpay/PIP will help ensure that you are not left to pay these expenses out of pocket.

3. **We do not charge for filing your Medpay or PIP.** As long as Murphy Chiropractic & Wellness, P.A. is filing my Medpay/PIP and, the insurance company is continuing to cover the charges accrued, collection of payment at time of service will be waived. If overpayment on my account is made, Murphy Chiropractic & Wellness, P.A. will refund the difference. I clearly understand and agree that all services rendered to me are charged directly to me, thus, I am personally responsible for payment in full.

Signature below of patient/Guardian indicates that you have read and accept above provisions.

Patient Name (please print):_____ Date: _____/_____/_____

Patient Signature:_____

If patient is under the age of 18:

Name of Custodial Parent or Legal Guardian (please print):_____

Parent/Guardian Signature:_____

ELECTION NOT TO FILE HEALTH INSURANCE CLAIMS

(Personal Injury/Accident)

The chiropractor at this clinic is a participating ("in-network") providers for your health benefit plan. As a participating provider, we are obligated to file claims for reimbursement with your plan for all covered services provided to you UNLESS you instruct us in writing not to file.

You have indicated that for services related to this personal injury, rather than using your own health insurance, you wish to consider seeking payment from other third-party payors such as the at-fault driver's liability insurance or Medpay.

By electing NOT to file claims on your health insurance:

The clinic will rely on your decision and extend credit to you for the cost of care based on the assumption that your bill will be paid by sources other than your health insurance. **You will be required to assign to the clinic the right to receive monies paid by liability insurers, medical payments insurers or other third-party payors to the extent necessary to satisfy your bill.**

You will not be required to pay co-payments/co-insurance and/or deductibles that would normally be required by your health benefit plan.

The cost of your treatment will be billed at the clinic's usual rates rather than the discounted rates that routinely apply to services covered by your health benefit plan.

If the combined payments received from other sources do not fully satisfy your bill, you may be personally liable for any unpaid balance.

None of the charges for your treatment will be applied towards satisfying the annual deductible (if applicable) associated with your health benefit plan.

Election not to file health insurance claims:

By my signature below, I attest that I have read and understand the above information regarding the election not to file claims on my insurance and have been given an opportunity to ask questions and to have those questions answered.

I hereby instruct the clinic not to file claims on my health insurance for services associated with this accident/injury, and I authorize the clinic to seek payment from, and send my treatment records to, other third-party payors who are potential sources of payment.

I understand that the clinic is relying on my decision not to file health insurance claims, and that with regards to claims related to this accident/injury, this decision is irrevocable.

I understand that no subsequent action on my part shall impair the clinic's right to bill and receive payments from third-party payors; subject only to any contractual obligation the clinic may have to my health benefit plan.

Patient Name (please print):_____ Date: _____/_____/_____

Patient Signature:_____

If patient is under the age of 18:

Name of Custodial Parent or Legal Guardian (please print):_____

Parent/Guardian Signature:_____