



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 patients 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: _____



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New Patient Paperwork

Date

First Name Phone 1

Last Name Home Mobile Work Other

DOB Phone 2

Sex Male Female Home Mobile Work Other

SSN Fax

Address Email

City Employer

State Employer Phone

Zip Code 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 ' " lbs
 Weight

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 Relationship

Last Name 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:

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Surgeries:

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Traumas:

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Allergies:

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Illnesses: Please check all that apply

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

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

Who? _____

What did they have? _____

Complaints:

- Neck
- Mid Back
- Low Back
- Left Shoulder
- Right Shoulder
- Left Knee
- Right Knee
- Left Elbow
- Right Elbow
- Left Wrist/Hand
- Right Wrist/Hand
- Left Ankle/Foot
- Right Ankle/Foot
- Other: _____

Does the pain travel anywhere else? No Yes. If yes, where? _____

Do you know what caused the problem? _____

Do you notice the pain during a certain time of day? No Yes. If yes, when? _____

Frequency: Constant (76-100%) Frequent (51-75%) Intermittent (26-50%) Occasional (1-25%)

Duration: Constant (>8 hrs) Frequent (6-8 hrs) Intermittent (3-5 hrs) Occasional (1-3 hrs) Infrequent (<1 hr)

Onset: When did the symptoms/pain begin? _____

Intensity: Slight Mild Moderate Severe

Is your condition: Same Better Worse

Rate your pain: 0 1 2 3 4 5 6 7 8 9 10

0 being no pain at all and 10 being the worst pain imaginable

Quality: Describe your pain: aching burning cramping deep dull numb radiating sharp
 shooting sore stabbing stiff swelling tight tingling throbbing

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

Have you been given a diagnosis for this problem? If so, what was the diagnosis? _____

What treatment(s) have you tried for your condition? None Medication Surgery Physical Therapy

Chiropractic Other _____

Are you presently under the care of a physical and/or mental health care provider? If so, by whom? _____

If so, what conditions? _____

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? _____

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
 Difficulty breathing Dizziness/lightheaded Fainting Irregular heartbeat Palpitations Persistent Coughing
 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 intolerance 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 BENEFITS

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. I 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 HIPAA 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, judgement, 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: _____