PERRY FAMILY CHIROPRACTIC, LLC

About You

Today's Date: ___/___/___
Patient Name:____
Last First MI
What you prefer to be called:____________________________
Male ☐ Female ☐
Birthday: ___/___/___ Age: ___
Mailing Address:____
____
City State Zip
Home Phone #: (___) ______________________________________
Work Phone #: (___)______________________________________
Cell Phone #: (___) ______________________________________
E-mail Address: ____
Referred By: ____
Employer: ______________________________ How Long? _____
Employer's Address: _____________________________________
____
City State Zip
Occupation: ____
Status: ☐ Minor ☐ Single ☐ Married
☐ Divorced ☐ Separated ☐ Widowed
Spouse's Name: ____
Do you have children? ☐ Yes ☐ No How many? _________

In Event of Emergency

Whom should we contact? ________________________________
Relation: ____
Home Phone #: (___) ____________________________________
Work Phone #: (___) ____________________________________
Cell Phone #: (___) _____________________________________
Primary Care Provider: _____________________________

Insurance Info

Primary
Co. Name:____
Address: ____
____
City State Zip
Phone #: (___) ____________________________________
Insured's ID #:__________________________________
Group # (Plan, Local, or Policy #): __________________________
Insured's Name: ____________________________________
Relation:________________________DOB:___/___/___
Insured's Employer:_________________________________

Account Info

Person ultimately responsible for account
Name:____
Relation: ____
Billing Address:__________________________________
____
City State Zip
Drivers License #: _________________________________
Work Phone #: (___) ________________________________
Payment Method: ☐ Cash ☐ Check
___________________________________ ___/___
☐ Credit Card – Enter card # above (if accepted)

______ I hereby authorize assignment of my insurance
(Initials) rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Signature: ____
Responsible Person
Date: ___/___/___

Reason For Visit

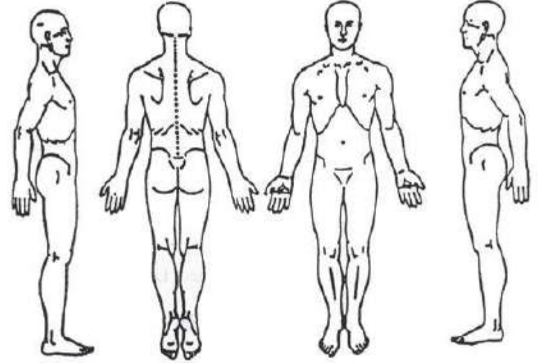
Reason for today's visit: ☐ Emergency ☐ New injury ☐ Old injury ☐ Chronic pain ☐ Wellness
Are you in pain: ☐ No ☐ Yes, Rate your pain with the following scale: Discomfort 1—2—3—4—5—6—7—8—9—10 Intense
When did your condition/accident occur? ___/___/___ Where did your injury occur? ________________________________
Please explain what happened: ____
Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes.
Is your condition interfering with your: ☐ Work ☐ Sleep or ☐ Daily routine? If so, how: ____________________________
____

Has this or something similar happened in the past?
☐ No ☐ Yes Explain: _______________________________
____
Have you been treated by a Physician for this condition?
☐No ☐Yes. If so, where? _________________
____
Have you ever been treated by a Chiropractor? ☐No ☐Yes.
Doctors name: _____________________________________

OFFICE USE ONLY

_____/_____ BP, _____ Height, _____ Weight, _____ Pulse, _____O2 Sat.

Use the body chart below and circle all affected areas:



Health History

Are you taking any of the following medications? ☐ Nerve pill ☐ Pain killers (including aspirin) ☐ Muscle relaxers
☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s) ____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Heart Surg. / Pacemaker	Y N Heart Murmur	Y N Congenital Hear Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N HIV + / AIDS / ARC
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Anemia / Diabetes
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe / Frequent Headaches	Y N Kidney Problems
Y N Ulcers / Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema / Asthma	Y N Tuberculosis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/Implants	Y N Arthritis

Please list any surgeries with dates and or any other serious medical condition(s) not listed above: ______________________
____
List any past serious accidents with dates: ____
Please list anything that you may be allergic to: ____
Family Health History: ____
Do you take supplements or vitamins? ☐No ☐Yes Do you exercise? ☐No ☐Yes ____ hours per week
Do you smoke? ☐No ☐Yes How much? __________ How long? __________
Are you wearing: ☐Shoe lifts ☐Inner soles ☐Arch supports
Are you dieting: ☐No ☐Yes Since: __/__/__
For Woman: Are you taking Birth Control? ☐No ☐Yes
Are you nursing? ☐No ☐Yes Are you pregnant? ☐No ☐Yes If so, how many weeks? ________________

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between doctor and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. IF account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services deeded during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
-

Signature ____ Date ___/___/___
☐Adult Patient, ☐ Parent or Guardian, ☐ Spouse

PERRY FAMILY
CHIROPRACTIC, LLC

Patient Non-Discrimination Notices

It is the policy of Perry Family Chiropractic not to engage in discrimination against, or harassment of, any person employed or seeking employment or patient care with Perry Family Chiropractic on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, pregnancy, physical, mental or other disability, medical condition, ancestry, marital status, age, sexual orientation, citizenship, or status as a veteran.

NOTICE OF PRIVACY PRACTICES

Dear patient:

This is not meant to alarm you! quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA -Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

The most significant variable that has· motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures, which we developed to make sure your health information, will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing and conducting health care operations

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEATH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health Information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in the training programs for students, interns, associates, and business and clinical employees. It is also possible, that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as

Documentation of Health Information
You have the right to ask us for a description of how and where your health information was used by our office for any reason than for treatment, payment or health care operations. Our documentation procedures will enable us to provide information on health information usage from April 13. 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.
Breach Notification: You will be notified of any breach of unsecured Patient Health Information.

PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

I have received the Perry Family Chiropractic Notice of Privacy Practices.

______________________________ _______________

Signature of Patient, Parent, or Legal Guardian Date

____

Relationship to Patient

____

Witness