Mason Family Chiropractic
1414 Country Club Road, Suite 2
Fairmont, WV 26554
p 304.534.8493
f 304.534.8268
drmariemason.medicfusion.com

Patient: _____

AUTHORIZATIONS AND RELEASES

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.

Initials: _____

Consent to Perform and Interpret X-rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

Initials: _____

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. For more information about Health Information Portability and Accountability Act (HIPAA) and health information privacy visit: hhs.gov - Understanding Health Information Privacy

- The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
- The patient has the right to examine and obtain a copy of their 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. This office is not obligated to agree to those restrictions.
- The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
- This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
- Patients have the right to file a formal complaint with our privacy official about any suspected violations.
- This office has the right to refuse treatment if the patient does not accept the terms of this policy.

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Financial Obligation and Appointment Policy

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

You may direct any questions regarding this financial obligation to the clinic manager or physician.

Initials: _____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor and certified staff have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to a fetus.

Initials: _____

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

Initials: _____

Insurance / Medicare payment-Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct.

I authorize this office and/or doctor to act as my agent in helping me obtain payment of my insurance and/ or Medicare benefits, and I authorize payment of these benefits to this clinic and/or doctor of record on my behalf for any services and materials furnished.

Initials: _____

Consent to Chiropractic Treatment

Please read this entire section regarding chiropractic care prior to accepting it. It is important that you understand the information contained in this section. Please ask questions before you accept it if there is anything that is unclear. You are the decision maker for your health care. Part of the role of this clinic is to provide you with information to assist you in making informed choices. This process is often referred to as 'informed consent' and involves your understanding and agreement regarding the care that this clinic recommends, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. The nature of the chiropractic analysis and treatment The primary treatment that is performed by a Doctor of Chiropractic is spinal manipulative therapy. This clinic may use that procedure to treat you. This may include the use of the hands or a mechanical instrument upon your body in such a way as restore normal joint motion. It may cause an audible 'pop' or 'click,' much as you have experienced when you 'crack' your knuckles. You may feel a sense of movement. Analysis/ Examination / Treatment As a part of the analysis, examination, and treatment, the doctor may want to employ a variety of procedures as may be deemed necessary. These procedures include but are not limited to: Spinal manipulative therapy, chiropractic adjustments, vital signs, range of motion

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testing, palpation, orthopedic testing, basic neurological testing, postural analysis testing, muscle strength testing, radiographic studies, scanning of feet, EMS, exercises, acupuncture, myofascial treatments, hot/cold therapy, mechanical traction, traction/decompression, laser therapy, vibrational pivot platform, or cranial balloon adjustments (CFR). By accepting this document you are consenting to these procedures as recommended/prescribed by this clinic. The material risks inherent in chiropractic adjustment. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation or from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an 'arterial dissection' that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which the provider will check during the taking of your history during examination and X-ray. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admissions attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons and the risk of death has been estimated at 140 per one million users. The availability and nature of other treatment options. Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted other treatment options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. The risks and dangers to remaining untreated. Remaining untreated may allow the formulation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed with the clinic any questions and concerns I have and they have been answered to my satisfaction. By accepting, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Initials: _____

Females: Consent to X-Ray During Pregnancy

This is to certify that, I am or may be pregnant and that the doctor or certified staff has my permission to perform diagnostic x-rays involving any cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be used over the trunk of my body. I have been advised that certain x-rays, particularly those involving the pelvis, can be hazardous to a fetus.

Initials: _____

Signature: _____ Date: _____

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Dear Patient:

Welcome to the world of Electronic Health Record keeping! Our practice has created a secure electronic patient record for you, allowing you to log into our site, create and update your private health record, and even schedule and re-schedule your own appointments.

Our free patient portal is available to you 24 hours a day, seven days a week, from the privacy and convenience of your own computer.

This system helps us work together to maintain safe, secure, accurate and up-to-date medical records for you. From now on, your important health information will be available to you when and where you need it, from any computer with a high-speed internet connection.

Registration, security and access are very similar to those used for on-line banking. To register, you will be required to provide the following information:

- Access Code: _____
- Your email address (your email address will be your user name for log-in purposes)
- A password (you will create a password during registration)

After registering, you will receive an activation email. This is very important! This email helps us verify that the email address you provide is working. When you receive the activation email, follow the instructions to activate your account and access it securely.

To get started, visit our web site:

drmariemason.medicfusion.com

Look for the Patient login icon. After you register and activate your account, you can log in and look around your electronic medical record. An on-page tutorial, located at the top-right of the page, provides a video tour of the system and its features.

Questions? Just ask us, or contact free tech support:

support@medicfusion.com

Thank you for helping us provide you with this free service!

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Patient Profile

Personal Information

Full Name: _____ Jr / Sr
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ H / M / B Alternate Phone: _____ H / M / B

Birth Date: ___/___/___

Social Security Number #: ___-___-___

Gender: ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined ☐ Unknown/Unavailable
☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined ☐ Unknown/Unavailable

Prim. Language: ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ German ☐ Greek ☐ Hebrew ☐ Italian
☐ Japanese ☐ Korean ☐ Spanish ☐ Vietnamese ☐ Declined ☐ Unknown/Unavailable
☐ Other _____

Email Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Time Zone: _____

Does your time zone participate in Daylight Savings Time? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Do you have any dependents? ☐ Yes ☐ No

Are you a full-time student? ☐ Yes ☐ No

Health Insurance? ☐ Yes ☐ No

Responsible Party: ☐ You ☐ Other (parent, spouse, etc.) _____

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Physician Form

Physician Information

Type of Physician: ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: _____
First Name *Last Name*

Address: _____
Street Address *Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Ext. Fax: _____

Email Address: _____

Type of Physician: ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: _____
First Name *Last Name*

Address: _____
Street Address *Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Ext. Fax: _____

Email Address: _____

Type of Physician: ☐ Chiropractic ☐ Family ☐ Specialist

Physician Name: _____
First Name *Last Name*

Address: _____
Street Address *Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Ext. Fax: _____

Email Address: _____

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Employer Form

Employer Information

Your Employment Status: ☐ Full Time ☐ Part Time ☐ Contract ☐ Not Employed ☐ Retired ☐ Student

Occupation or Title: _____

Employer Name: _____

Employer Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Employer Phone: _____ Ext. Fax: _____

Start Date: / / End Date: (If you are no longer working here.) / /

Your Employment Status: ☐ Full Time ☐ Part Time ☐ Contract ☐ Not Employed ☐ Retired ☐ Student

Occupation or Title: _____

Employer Name: _____

Employer Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Employer Phone: _____ Ext. Fax: _____

Start Date: / / End Date: (If you are no longer working here.) / /

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Responsible Party Form

Responsible Party Information

Relationship to You: _____

Full Name: _____
First *M.I.* *Last*

Same as your address? ☐ Yes ☐ No

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

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Health Insurance Information

Are you the insured party? ☐ Yes ☐ No (if no please fill out the Policy Holder Information)

Policy Holder Information

Full Name: _____
Last *First* *M.I.*

Relationship to you: _____

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Birth Date: ___/___/___

Social Security Number #: ___-___-___

Insured's Occupation: _____

Insured's Employer: _____

Employer Address: _____
Street Address *Unit #*

_____
City *State* *ZIP Code*

Employer Phone: _____ Ext. _____

Insurance Company Information

Insurance Company Name: _____

Address: _____
Street Address *Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Ext. _____ Fax: _____

Group #: _____

Policy/Subscriber #: _____

Effective Date: ___/___/___ Expiration Date: ___/___/___

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Patient: ______________________________

Health History Form

Prescription Medications

Prescription medications taken on a regular or ongoing basis:

Medication: __________________ Dosage: _________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________________________

Medication: __________________ Dosage: _________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________________________

Medication: __________________ Dosage: _________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________________________

Medication: __________________ Dosage: _________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________________________

Medication: __________________ Dosage: _________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________________________

Medication: __________________ Dosage: _________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________________________

Medication: __________________ Dosage: _________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________________________

Medication: __________________ Dosage: _________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________________________

Medication: __________________ Dosage: _________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________________________

Medication: __________________ Dosage: _________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________________________

Medication: __________________ Dosage: _________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________________________

Medication: __________________ Dosage: _________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ________________________________

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Over-The-Counter Medications

Over-the-counter medications taken on a regular or ongoing basis:

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

Medication: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________

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Vitamins, Minerals, Herbs, or Dietary Supplements

Vitamins, minerals, herbs, or dietary supplements taken on a regular or ongoing basis:

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

Supplement: ____________ Dosage: ________ Frequency: per ☐ Day ☐ Week ☐ Month ☐ Other
(please describe): ____________________

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Diet and Exercise

Check if you have ever smoked cigars or cigarettes. ☐ Yes

Check if you still smoke. ☐ Yes

How much do you smoke? ☐ Less than one pack per week ☐ 1-2 packs per week

☐ 1 pack every two days ☐ 1 pack per day ☐ More than one pack per day

Check if you drink alcoholic beverages. ☐ Yes

How many alcoholic beverages do you consume per week? _____

Check if a physician has ever diagnosed you as an alcoholic. ☐ Yes

Check if a physician has ever diagnosed you with any liver-related problems. ☐ Yes

Check if you exercise regularly. ☐ Yes

How many days do you exercise each week? _____

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Allergies

Check if a physician has ever diagnosed you with any allergies. ☐ Yes

Do you have Airborne allergies? ☐ Yes

☐ Animal ☐ Molds/Fungus ☐ Pollens ☐ Other _____

☐ Cat Hair ☐ Cockroach ☐ Dog Hair ☐ Feather Mix

☐ Guinea Pig Hair ☐ Dust Mites ☐ Other _____

Do you have Chemical allergies? ☐ Yes

☐ Acetone ☐ Acetylcholine ☐ Auto Exhaust ☐ Benzyl Alcohol ☐ Chlorine

☐ Citric Acid ☐ Cologne (all) ☐ Diesel Exhaust ☐ Dopamine ☐ Estradiol

☐ Ethanol ☐ Fluorine ☐ Formaldehyde ☐ Latex ☐ Melatonin

☐ Newspaper Print ☐ Norepinephrine ☐ Progesterone ☐ Propylene ☐ Serotonin

☐ Silicone Implant ☐ Sponge Rubber ☐ Toluene ☐ Trichloroethylene ☐ Wood Pulp

☐ Xylene ☐ Other _____

Do you have Drug allergies? ☐ Yes

☐ Anticonvulsants ☐ Codeine ☐ Insulin Preparations ☐ Iodine ☐ Morphine

☐ Novocain ☐ Penicillin ☐ Sulfa ☐ Other _____

Do you have Food allergies? ☐ Yes

☐ Artificial Colorings ☐ Artificial Flavorings ☐ Beef ☐ Coffee/Tea ☐ Dairy

☐ Eggs ☐ Fish/Shellfish ☐ Fruits ☐ Lamb ☐ Nuts

☐ Pork ☐ Poultry ☐ Vegetables ☐ Other _____

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Surgical History

Check if you have any implants, screws, plates or other foreign objects in your body. ☐ Yes

☐ Bullet Wound(s) ☐ Infusion Catheter ☐ Ear Implant ☐ Pacemakers ☐ Eye Implant

☐ Brain Plate(s) ☐ Heart Valve(s) ☐ Shrapnel ☐ Other _____

Musculoskeletal Surgeries (Check if you have had any of the following surgeries)

☐ Ankle	Year(s) of surgery: _____		☐ Head	Year(s) of surgery:	_____
☐ Back	Year(s) of surgery: _____		☐ Hip	Year(s) of surgery:	_____
☐ Cosmetic or Augmentation	Year(s) of surgery: _____		☐ Knee	Year(s) of surgery:	_____
☐ Elbow	Year(s) of surgery: _____		☐ Neck	Year(s) of surgery:	_____
☐ Foot	Year(s) of surgery: _____		☐ Shoulder	Year(s) of surgery:	_____
☐ Hand	Year(s) of surgery: _____		☐ Wrist	Year(s) of surgery:	_____
☐ Other	Please describe: _____			Year(s) of surgery:	_____

Organ System Surgeries (Check if you have had any of the following surgeries)

☐ Brain	Year(s) of surgery: _____		☐ Intestine, large	Year(s) of surgery:	_____
☐ Colon	Year(s) of surgery: _____		☐ Liver	Year(s) of surgery:	_____
☐ Esophagus	Year(s) of surgery: _____		☐ Lung	Year(s) of surgery:	_____
☐ Eye	Year(s) of surgery: _____		☐ Mastectomy	Year(s) of surgery:	_____
☐ Heart	Year(s) of surgery: _____		☐ Reproductive Organs	Year(s) of surgery:	_____
☐ Kidney	Year(s) of surgery: _____		☐ Skin	Year(s) of surgery:	_____
☐ Intestine, small	Year(s) of surgery: _____		☐ Throat	Year(s) of surgery:	_____
☐ Other	Please describe: _____			Year(s) of surgery:	_____
☐ Transplant	Please describe: _____			Year(s) of surgery:	_____

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Your Cancer History

Check if a physician has ever diagnosed you with cancer. ☐ Yes

Check all that apply

☐ Bladder
☐ Brain
☐ Breast
☐ Cervical
☐ Colon or Rectal
☐ Endometrial
☐ Eye
☐ Kidney (renal cell)
☐ Leukemia
☐ Other _____
☐ Lung
☐ Non-Hodgkin's Lymphoma
☐ Ovarian
☐ Pancreatic
☐ Prostate
☐ Skin
☐ Basal Cell Carcinoma
☐ Squamous Cell Carcinoma
☐ Melanoma
☐ Stomach
☐ Thyroid
☐ Uterine

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Family Cancer History

Check if a physician has ever diagnosed your family with cancer. ☐ Yes

Check all that apply and the family member(s) who had this condition:

☐ *Bladder (M, F, S, MG, PG)*
☐ *Brain (M, F, S, MG, PG)*
☐ *Breast (M, F, S, MG, PG)*
☐ *Cervical (M, F, S, MG, PG)*
☐ *Colon or Rectal (M, F, S, MG, PG)*
☐ *Endometrial (M, F, S, MG, PG)*
☐ *Eye (M, F, S, MG, PG)*
☐ *Kidney (renal cell) (M, F, S, MG, PG)*
☐ *Leukemia (M, F, S, MG, PG)*
☐ Other _____ *(M, F, S, MG, PG)*

☐ *Lung (M, F, S, MG, PG)*
☐ *Non-Hodgkin's Lymphoma (M, F, S, MG, PG)*
☐ *Ovarian (M, F, S, MG, PG)*
☐ *Pancreatic (M, F, S, MG, PG)*
☐ *Prostate (M, F, S, MG, PG)*
☐ *Skin (M, F, S, MG, PG)*
☐ *Basal Cell Carcinoma (M, F, S, MG, PG)*
☐ *Squamous Cell Carcinoma (M, F, S, MG, PG)*
☐ *Melanoma (M, F, S, MG, PG)*
☐ Stomach *(M, F, S, MG, PG)*
☐ Thyroid *(M, F, S, MG, PG)*
☐ Uterine *(M, F, S, MG, PG)*

Family Members	
(M)	Mother
(F)	Father
(S)	Sibling
(MG)	Maternal Grandparent
(PG)	Paternal Grandparent

Mason Family Chiropractic
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Your Cardio-pulmonary / Circulatory Health

Check if a physician has ever diagnosed you with any of the following:

- ☐ Anemia
- ☐ HIV/AIDS
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hypertension (high blood pressure)
- ☐ Hypotension (low blood pressure)
- ☐ Hemorrhoids
- ☐ Lung Disorders
  - ☐ Acute Respiratory Distress Syndrome
  - ☐ Alpha-1 Antitrypsin Deficiency
  - ☐ Asbestos/Dust Disease
  - ☐ Asthma
  - ☐ Bronchiectasis
  - ☐ Bronchitis (chronic)
  - ☐ Bronchopulmonary Dysplasia (BPD)
  - ☐ Chronic Obstructive Pulmonary Disease
  - ☐ Cystic Fibrosis
  - ☐ Emphysema
  - ☐ Farmer's Lung
  - ☐ Hantavirus
  - ☐ Histoplasmosis
  - ☐ Legionellosis
  - ☐ Lymphangioleiomyomatosis
  - ☐ Pleurisy
  - ☐ Pneumonia
  - ☐ Pneumothorax
  - ☐ Primary Alveolar Hypoventilation Syndrome
  - ☐ Pulmonary Alveolar Proteinosis
  - ☐ Pulmonary Embolus
  - ☐ Pulmonary Fibrosis
  - ☐ Respiratory Distress Syndrome
  - ☐ Respiratory Syncytial Virus
  - ☐ Sarcoidosis
  - ☐ Severe Acute Respiratory Syndrome
  - ☐ Spontaneous Pneumothorax
  - ☐ Tuberculosis
- ☐ Raynaud's Phenomenon
- ☐ Sickle Cell Anemia
- ☐ Sinus Infections (chronic)
- ☐ Stroke
- ☐ Wegener's Granulomatosis
- ☐ Other _____

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Family Cardio-pulmonary / Circulatory Health

Check if a physician has ever diagnosed your family with any of the following:

- ☐ Anemia *(M, F, S, MG, PG)*
- ☐ HIV/AIDS *(M, F, S, MG, PG)*
- ☐ Hemophilia *(M, F, S, MG, PG)*
- ☐ Hepatitis *(M, F, S, MG, PG)*
- ☐ Hypertension (high blood pressure) *(M, F, S, MG, PG)*
- ☐ Hypotension (low blood pressure) *(M, F, S, MG, PG)*
- ☐ Hemorrhoids *(M, F, S, MG, PG)*
- ☐ Lung Disorders *(M, F, S, MG, PG)*

- ☐ Acute Respiratory Distress Syndrome *(M, F, S, MG, PG)*
- ☐ Alpha-1 Antitrypsin Deficiency *(M, F, S, MG, PG)*
- ☐ Asbestos/Dust Disease *(M, F, S, MG, PG)*
- ☐ Asthma *(M, F, S, MG, PG)*
- ☐ Bronchiectasis *(M, F, S, MG, PG)*
- ☐ Bronchitis (chronic) *(M, F, S, MG, PG)*
- ☐ Bronchopulmonary Dysplasia(BPD) *(M, F, S, MG, PG)*
- ☐ Chronic Obstructive Pulmonary Disease *(M, F, S, MG, PG)*
- ☐ Cystic Fibrosis *(M, F, S, MG, PG)*
- ☐ Emphysema *(M, F, S, MG, PG)*
- ☐ Farmer's Lung *(M, F, S, MG, PG)*
- ☐ Hantavirus *(M, F, S, MG, PG)*
- ☐ Histoplasmosis *(M, F, S, MG, PG)*
- ☐ Legionellosis *(M, F, S, MG, PG)*
- ☐ Lymphangioleiomyomatosis *(M, F, S, MG, PG)*
- ☐ Pleurisy *(M, F, S, MG, PG)*
- ☐ Pneumonia *(M, F, S, MG, PG)*
- ☐ Pneumothorax *(M, F, S, MG, PG)*
- ☐ Primary Alveolar Hypoventilation Syndrome *(M, F, S, MG, PG)*
- ☐ Pulmonary Alveolar Proteinosis *(M, F, S, MG, PG)*
- ☐ Pulmonary Embolus *(M, F, S, MG, PG)*
- ☐ Pulmonary Fibrosis *(M, F, S, MG, PG)*
- ☐ Respiratory Distress Syndrome *(M, F, S, MG, PG)*
- ☐ Respiratory Syncytial Virus *(M, F, S, MG, PG)*
- ☐ Sarcoidosis *(M, F, S, MG, PG)*
- ☐ Severe Acute Respiratory Syndrome *(M, F, S, MG, PG)*
- ☐ Spontaneous Pneumothorax *(M, F, S, MG, PG)*
- ☐ Tuberculosis *(M, F, S, MG, PG)*

- ☐ Raynaud's Phenomenon *(M, F, S, MG, PG)*
- ☐ Sickle Cell Anemia *(M, F, S, MG, PG)*
- ☐ Sinus Infections (chronic) *(M, F, S, MG, PG)*
- ☐ Stroke *(M, F, S, MG, PG)*
- ☐ Wegener's Granulomatosis *(M, F, S, MG, PG)*
- ☐ Other _____ *(M, F, S, MG, PG)*

Family Members	
(M)	Mother
(F)	Father
(S)	Sibling
(MG)	Maternal Grandparent
(PG)	Paternal Grandparent

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Endocrine, Gastrointestinal and Neurologic Health

Check if a physician has ever diagnosed you with any of the following:

- ☐ Autoimmune Disorder
  - ☐ Dermatitis
  - ☐ Churg-Strauss (Allergic Granulomatosis)
  - ☐ Eosinophilic Fasciitis
  - ☐ Dermatomyositis/Polymyositis
  - ☐ Goodpasture's Syndrome
  - ☐ Interstitial Granulomatous Dermatitis with Arthritis
  - ☐ Lupus
    - ☐ Lupus SLE
    - ☐ Lupus DLE
    - ☐ Lupus SCLE
    - ☐ Anti-Phospholipid Antibody Syndrome (Lupus Anticoagulant)
  - ☐ Mixed Connective Tissue Disease
  - ☐ Relapsing Polychondritis
  - ☐ Rheumatoid Arthritis
  - ☐ Sarcoidosis
  - ☐ Scleroderma
  - ☐ Sjogren's Syndrome
  - ☐ Skin Immunofluorescence
  - ☐ Vasculitis
- ☐ Bladder Disease
- ☐ Candida
- ☐ Chicken Pox
- ☐ Chronic Fatigue Syndrome
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gall Bladder Problems
- ☐ Headaches
  - ☐ Cluster Headaches
  - ☐ Migraine Headaches
  - ☐ Sinus Headaches
  - ☐ Stress-induced Headaches
  - ☐ Tension Headaches
- ☐ Incontinence
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Liver Problems
- ☐ Measles
- ☐ Mumps
- ☐ Seizures
- ☐ Shingles
- ☐ Stomach Ulcers
- ☐ Thyroid Dysfunction
- ☐ Urinary Tract Infection
- ☐ Other _____

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Emotional and Mental Health

Check if a physician has ever diagnosed you with an emotional or mental condition. ☐ Yes

- ☐ Anger Disorders
- ☐ Anxiety Disorders
- ☐ Asperger Syndrome
- ☐ Attention Deficit Disorder with Hyperactivity (ADHD)
- ☐ Autistic Disorder
- ☐ Avoidant Personality Disorder (AvPD)
- ☐ Bipolar Disorder
- ☐ Borderline Personality Disorder
- ☐ Capgras Syndrome
- ☐ Child Behavior Disorders
- ☐ Combat Disorders
- ☐ Cyclothymic Disorder
- ☐ Dependent Personality Disorder (DPD)
- ☐ Depressive Disorders (depression)
- ☐ Dissociative Disorders
- ☐ Dysthymic Disorders (mood disorder)
- ☐ Eating Disorders
- ☐ Firesetting Behavior
- ☐ Hypochondriasis (Somatoform Disorder)
- ☐ Impulse Control Disorders
- ☐ Kleine-Levin Syndrome
- ☐ Kleptomania
- ☐ Multiple Personality Disorder
- ☐ Munchhausen Syndrome
- ☐ Narcissistic Personality Disorder
- ☐ Narcolepsy
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Phobic Disorders (Phobias)
- ☐ Psychotic Disorders
- ☐ Restless Legs Syndrome
- ☐ Schizophrenia
- ☐ Seasonal Affective Disorder
- ☐ Sexual or Gender Disorders
- ☐ Sexual Dysfunctions (psychological, not physical)
- ☐ Sleep Disorders
- ☐ Post-traumatic Stress Syndrome
- ☐ Substance Abuse
- ☐ Suicidal Tendencies
- ☐ Other _____

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Sensory Health

Check if a physician has ever diagnosed you with any of the following:

- ☐ Blindness
- ☐ Cataract
- ☐ Cholesteatoma
- ☐ Deafness or Hearing Loss
- ☐ Ear ringing
- ☐ Eczema
- ☐ Glaucoma
- ☐ Laryngitis (chronic)
- ☐ Macular Degeneration
- ☐ Mumps
- ☐ Meniere's Disease
- ☐ Nasal Polyps
- ☐ Perforated Eardrum
- ☐ Psoriasis
- ☐ Rhinitis
- ☐ Sinusitis
- ☐ Tinnitus
- ☐ Unusual Vision Impairment
- ☐ Vertigo
- ☐ Other _____

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Musculoskeletal Health

Check if a physician has ever diagnosed you with any of the following:

☐ Arthritis

☐ Ankylosing Spondylitis	☐ Behets Disease
☐ Carpal Tunnel Syndrome	☐ Diffuse Idiopathic Skeletal Hyperostosis (DISH)
☐ Ehlers-Danlos Syndrome (EDS)	☐ Felty's Syndrome
☐ Fibromyalgia	☐ Infectious Arthritis
☐ Mixed Connective Tissue Disease (MCTD)	☐ Osteoarthritis
	☐ Osteoporosis
☐ Paget's Disease	☐ Polymyalgia Rheumatica
☐ Polymyositis and Dermatomyositis	☐ Pseudogout
	☐ Psoriatic Arthritis
☐ Reactive Arthritis	☐ Repetitive Stress Injury
☐ Rheumatoid Arthritis	☐ Scleroderma
☐ Sjogren's Syndrome	☐ Stills Disease

☐ Gout
☐ Herniated Disk
☐ Lyme Disease
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Numbness or Tingling in feet
☐ Numbness or Tingling in hands
☐ Osteoporosis
☐ Parkinson's Disease
☐ Pinched Nerve
☐ Polio
☐ Rheumatism
☐ Sciatica
☐ Temporomandibular Joint Syndrome (TMJ)
☐ Other _____

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Reproductive Health

Check if you have ever given birth. ☐ Yes

How many births vaginally? _____

How many births by C-section? _____

Check if a physician has ever diagnosed you with any of the following:

☐ Chlamydia ☐ Dysplasia ☐ Erectile Dysfunction ☐ Genital Herpes

☐ Gonorrhea ☐ Human Papillomavirus (HPV) ☐ Impotency ☐ Syphilis

☐ Infertility ☐ Cystitis ☐ Menopause ☐ Prostate Enlargement

☐ Testicular Dysfunction ☐ Uterine Fibroid ☐ Vaginal Yeast Infections (chronic) ☐ Other _____

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Patient: _____

New Case Questionnaire - Injury / Complaint Short Form

CHIEF COMPLAINT

Your current concern(s):

☐ Headaches ☐ Neck pain ☐ Low back pain ☐ Mid back pain ☐ Shoulder pain
☐ Elbow pain ☐ Hip pain ☐ Knee pain ☐ Other

Other concern(s): _____

When did your symptoms begin? If unknown please estimate: _____

[Female Patients] Are you pregnant? ◯ Yes ◯ No

If yes, estimate your due date: _____ If no, date of most recent menstrual cycle: _____

Which word best describes the frequency of your symptoms:

◯ Occasional (0-25%) ◯ Intermittent (26-50%) ◯ Frequent (51-75% ◯ Constant (75-100%)

Which phrases best describe changes in your symptoms during the day? (select all that apply)

☐ Worse in the morning ☐ Worse in the afternoon ☐ Worse at night
☐ Changes with the weather ☐ Does not change

What helps to relieve your symptoms? (select all that apply)

☐ Ice ☐ Heat ☐ Medication ☐ Physical therapy
☐ Acupuncture ☐ Massage ☐ Nothing ☐ Other

Other relief: _____

What activities are limited by your symptoms? (select all that apply)

☐ Bending ☐ Bowel movement ☐ Coughing ☐ Daily routine
☐ Driving ☐ Getting up ☐ Lifting ☐ Lying down
☐ Pulling ☐ Pushing ☐ Reading ☐ Sitting
☐ Sleeping ☐ Sneezing ☐ Standing ☐ Turning head
☐ Urination ☐ Walking ☐ Working ☐ Other

Other activities: _____

Approximate date of your most recent Physical Exam: _____

Approximate date of your most recent Spinal x-ray: _____

Approximate date of your most recent MRI: _____

Approximate date of your most recent CT scan: _____

Approximate date of your most other scans: _____

Approximate date of your most recent Dental x-rays: _____

Other scans description: _____

PRIOR TREATMENT

Have you tried other medical treatments for this condition? ◯ Yes ◯ No

Specify treatment provider:

◯ Hospital or Urgent care ◯ Medical Physician ◯ Chiropractor ◯ Massage Therapist

◯ Physical Therapist ◯ Acupuncturist ◯ Other

Other treatment provider: _____

Start date of prior treatment: _____ End date of prior treatment: _____

This office requires a copy of the medical report detailing your treatment:

◯ I will provide a copy ◯ i will fax it

◯ I will e-mail it ◯ I authorize my former facility to release my records

Physician Information:

Name of Physician: _____

Name of facility: _____

Address: _____

City _____

State _____ Zip _____

Phone Number _____

ACCIDENT DETAILS

Are your symptoms a result of an accident? ◯ Yes ◯ No

Date of accident? If unknown, please estimate; _____

In what State did the accident happen? _____

What type of accident did you have? ◯ Other

Other accident information

_____

Have you taken time of work as a result? ◯ Yes ◯ No

Are you still off work? ◯ Yes ◯ No

Beginning date _____ Ending date _____

Were you compensated for time lost from work? ◯ Yes ◯ No

ACCIDENT PARTIES

Is there an attorney handling your case? ◯ Yes ◯ No

Attorney information:

Attorney name: _____

Firm name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone number: _____ Fax number: _____

Email address: _____

Other financially involved party: ◯ Yes ◯ No ◯ Unknown

Other financially involved party information:

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone number: _____

Other insurance party: ◯ Yes ◯ No ◯ Unknown

Other insurance party information

Contact name: _____

Company name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone number: _____

Fax number: _____

Email address: _____

Claim number: _____

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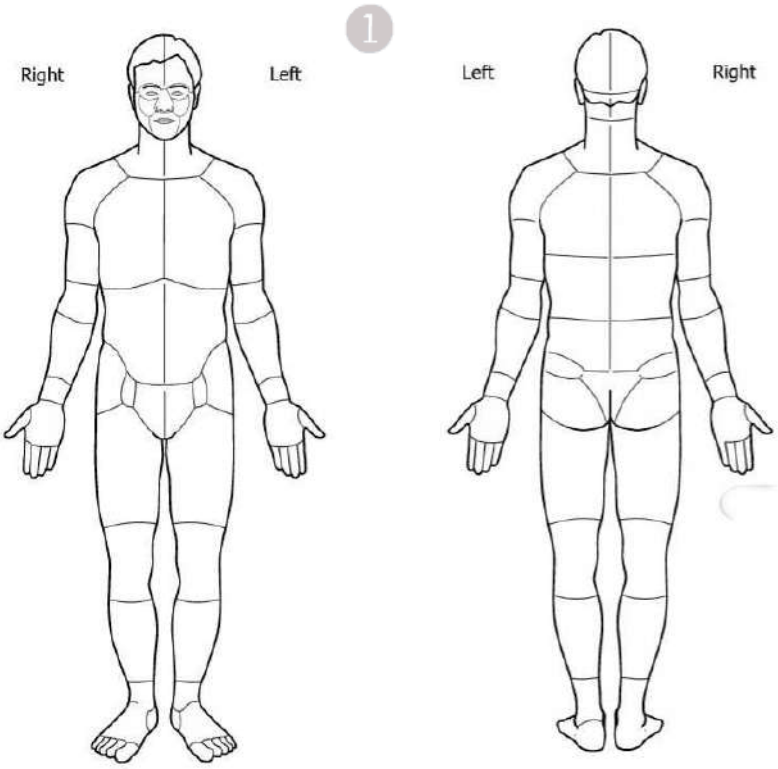
Patient: _____

Patient Symptom Illustrator

Patient Symptom Illustrator

Front **Back**



Instructions:

1. Identify your areas of discomfort by marking the affected body parts in the illustration.
2. Indicate the area name along with your specific symptoms associated with each selected area.
3. Rate your discomfort associated with each selected area.

		Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness	0 = No Discomfort 10 = Severe Discomfort
Ex.	L (R) Lower Back			X			X			X	0 1 2 3 4 5 6 X 8 9 10
1.	L R										0 1 2 3 4 5 6 7 8 9 10
2.	L R										0 1 2 3 4 5 6 7 8 9 10
3.	L R										0 1 2 3 4 5 6 7 8 9 10
4.	L R										0 1 2 3 4 5 6 7 8 9 10

MASON FAMILY CHIROPRACTIC

NPI #: 1578572160 Tax ID #: 550778547

1414 Country Club Rd., Suite #2 Fairmont, WV 26554

304-534-8493

Patient Information

Name: _____ Date of Birth: ____/____/_____
Patient ID #: _____

Mailing Address (city | state | zip):_____
Phone Number: (_____)_____ [ ] home [ ] cell
Email Address: _____
Contact Preference: [ ] by mail [ ] by email [ ] by phone

Good Faith Estimate for Health Care Items and Services

An itemized list of items or services that are "reasonably expected" to be furnished:
Date of First Visit: _____
This estimate covers dates through: _____

Services and Codes	Regular Pricing	ChiroHealth USA Pricing
New Patient Exams 99202 - 99205	$175.00 - $275.00	$131.25 - $206.25
Established Patient Re-Exam 99211 99212 99213	$ 40.00 $ 80.00 $125.00	$ 30.00 $ 60.00 $ 82.50
Chiropractic Adjustment 98943 98940 98941	$ 40.00 $ 45.00 $ 70.00	$ 30.00 $ 45.00 $ 45.00
Non-Supplemental Supplies (ex. Biofreeze, Pillows, Orthotics)	$ 5.00 - $ 500.00 Varies according to product	10% Off
Nutritional Supplements (prices may change	$ 7.00 - $107.00 Varies according to product	10% Off
Physiotherapies per unit Laser Therapy per unit	$ 40.00 - $ 53.00 $ 40.00	$ 30.00 - $ 39.75 $ 40.00

***ChiroHealth Discounts EXCLUDE:**
ALL Laser Therapies, Vitamin D Hydroxy Tests and ALL individual lab tests.

X-Ray Services are NOT offered at this facility

Your Estimated Care Plan:

Diagnosis Code(s):

_____

Expected Exam CPT code for your care: _____

Expected Adjustment CPT codes for your care:
_____ for _____ visits.

Expected physiotherapy CPT codes for your care:
_____ for _____ visits.

Expected total number of visits expected for you care: _____

Expected Supplement charges for your care: _____

Total Estimated Monthly Charges for your care*: _____

*This is an estimated cost only covering date stated. More (or less) visits may be needed. If your condition requires other (outside) testing, such as an MRI or Lab, you will receive a separate estimate and billing directly from them.

If we anticipate any outside scheduling it would be:

_____

List of items from other providers that will require separate scheduling if applicable:

_____

_____

Please Note:

- Disclaimer: there may be other services required that must be scheduled separately during the course of treatment and are not included in the Good Faith Estimate (GFE)
- Disclaimer: this is only an estimate and actual services, and charges may differ
- Disclaimer: GFE is not a contract, and the patient is not required to obtain services from this provider
- You have the right to receive a “Good Faith Estimate” explaining how much your medical health care will cost.
- Under the law, health care providers need to give patients who don’t have insurance or who are not using insurance an estimate of the expected charges for medical services
- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services
- You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate
- For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises
- Complaints about medical billing - You can submit a complaint about a medical billing experience you had, whether you’re insured or uninsured. https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing