# WELCOME

## PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

## INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

## PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

**IN CASE OF EMERGENCY, CONTACT**

Name _____

Relationship _____

Home Phone (____) _____

Work Phone (____) _____

## ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

## PATIENT CONDITION

Reason for Visit _____

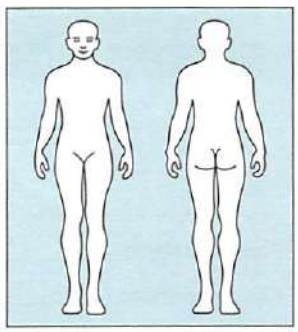
When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

## HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

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

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No | Liver Disease | ☐ Yes ☐ No | Rheumatic Fever | ☐ Yes ☐ No |
| Alcoholism | ☐ Yes ☐ No | Emphysema | ☐ Yes ☐ No | Measles | ☐ Yes ☐ No | Scarlet Fever | ☐ Yes ☐ No |
| Allergy Shots | ☐ Yes ☐ No | Epilepsy | ☐ Yes ☐ No | Migraine Headaches | ☐ Yes ☐ No | Sexually Transmitted Disease | ☐ Yes ☐ No |
| Anemia | ☐ Yes ☐ No | Fractures | ☐ Yes ☐ No | Miscarriage | ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No |
| Anorexia | ☐ Yes ☐ No | Glaucoma | ☐ Yes ☐ No | Mononucleosis | ☐ Yes ☐ No | Suicide Attempt | ☐ Yes ☐ No |
| Appendicitis | ☐ Yes ☐ No | Goiter | ☐ Yes ☐ No | Multiple Sclerosis | ☐ Yes ☐ No | Thyroid Problems | ☐ Yes ☐ No |
| Arthritis | ☐ Yes ☐ No | Gonorrhea | ☐ Yes ☐ No | Mumps | ☐ Yes ☐ No | Tonsillitis | ☐ Yes ☐ No |
| Asthma | ☐ Yes ☐ No | Gout | ☐ Yes ☐ No | Osteoporosis | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Bleeding Disorders | ☐ Yes ☐ No | Heart Disease | ☐ Yes ☐ No | Pacemaker | ☐ Yes ☐ No | Tumors, Growths | ☐ Yes ☐ No |
| Breast Lump | ☐ Yes ☐ No | Hepatitis | ☐ Yes ☐ No | Parkinson's Disease | ☐ Yes ☐ No | Typhoid Fever | ☐ Yes ☐ No |
| Bronchitis | ☐ Yes ☐ No | Hernia | ☐ Yes ☐ No | Pinched Nerve | ☐ Yes ☐ No | Ulcers | ☐ Yes ☐ No |
| Bulimia | ☐ Yes ☐ No | Herniated Disk | ☐ Yes ☐ No | Pneumonia | ☐ Yes ☐ No | Vaginal Infections | ☐ Yes ☐ No |
| Cancer | ☐ Yes ☐ No | Herpes | ☐ Yes ☐ No | Polio | ☐ Yes ☐ No | Whooping Cough | ☐ Yes ☐ No |
| Cataracts | ☐ Yes ☐ No | High Blood Pressure | ☐ Yes ☐ No | Prostate Problem | ☐ Yes ☐ No | Other _____ | |
| Chemical Dependency | ☐ Yes ☐ No | High Cholesterol | ☐ Yes ☐ No | Prosthesis | ☐ Yes ☐ No | | |
| Chicken Pox | ☐ Yes ☐ No | Kidney Disease | ☐ Yes ☐ No | Psychiatric Care | ☐ Yes ☐ No | | |
| | | | | Rheumatoid Arthritis | ☐ Yes ☐ No | | |

### EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

### WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

### HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

| Injuries/Surgeries you have had | Description | Date |
|---|---|---|
| Falls | | |
| Head Injuries | | |
| Broken Bones | | |
| Dislocations | | |
| Surgeries | | |

### MEDICATIONS

_____
_____
_____
Pharmacy Name _____
Pharmacy Phone (____) _____

### ALLERGIES

_____
_____
_____
_____
_____

### VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

Bayside Chiropractic
Dr. Leslie M Bryan
11280 # A Hwy 31
Spanish Fort, AL 36527

PLEASE PRINT

Name_____

File# _____

*Telephone Communication Preferences*

| Location | Number | Can we call you here? | | Can we leave a message? | |
|---|---|---|---|---|---|
| Home | _____ | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Work | _____ | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Cell | _____ | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Other | _____ | ☐ Yes | ☐ No | ☐ Yes | ☐ No |

*Mail Communication Preferences* - **PERSONAL OFFICE USE ONLY!**

May we send mail to your home address? (For example, Birthday Cards, Promotional Cards, Newsletters, etc)
If no, please provide an Alternate mailing address below. ☐ Yes ☐ No

_____

_____

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk about your health care information? (Check all that apply)

| | Name | Telephone |
|---|---|---|
| ☐ Spouse | _____ | _____ |
| ☐ Caretaker | _____ | _____ |
| ☐ Child | _____ | _____ |
| ☐ Parent | _____ | _____ |
| ☐ Other | _____ | _____ |

Do you have any health information that you would like to be kept confidenrial from any person or persons?
If so,please specifically describe the information and person or persons below:

_____

_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or personal Representative Signature Date

_____ _____

Printed Name Relationship to Patient Relationship to Patient

## INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND 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 who now or in the future treat me while employed by, working, or associated with, serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

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

I understand an am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but limited to: fracture, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had 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(s) and for any future condition(s) for which I seek treatment.

To be completed by patient:

_____
Print Patient's Name

_____
Patient's Signature

_____
Date Signed

To be completed by patient's representative. If necessary, e.g., if patient is a minor or is physically or mentally incapacitated:

_____
Print Name of Patient

_____
Print Name of Patient's Representative

_____
Signature of Patient's Representative

As_____
Relationship or Authority of Patient's Representative

_____
Date Signed

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To be completed by Doctor or staff:

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Name and address of clinic/office:
**Bayside Chiropractic**
**Dr. Leslie M Bryan**
**11280 #A Hwy 31**
**Spanish Fort, AL 36527**

Print name(s) of doctor(s) treating this patient:

Dr. Leslie Bryan
Dr. Crystal Wachtel

_____
Witness to Patient's Signature

Date

# ASSIGNMENT OF BENEFITS & HIPPA RELEASE FORM

Please check any and all insurance coverage that may be applicable in this case:

▪Major Medical ▪Worker's Compensation ▪Medicaid ▪Medicare ▪Auto Accident

▪Medical Savings Account & Flex Plans ▪Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company: _____

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic are, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive you medical records, please inform our office.**

Patient Signature: _____ Date: _____

Guardian Signature Authorizing Care: _____ Date: _____

TO: Medicare Patients,

To make dealing with Medicare as simple as possible, we have established the following guidelines. Keep in mind that Medicare regulations change frequently and therefore, these guidelines may have to be updates.

1. WE WILL FILE ALL MEDICARE CLAIMS.
2. WE WILL FILE ALL MEDICARE SECONDARY/SUPPLEMENTAL INSURANCE.
3. WE ARE PARTICIPATING PROVIDERS WITH MEDICARE WHICH MEANS THAT MEDICARE PAYS DIRECTLY, HOWEVER, MEDICARE PATIENTS MUST MEET AN ANNUAL $198 DEDUCTIBLE, WHICH WE ARE REQUIRED TO COLLECT AT THE BEGINNING OF SERVICES FOR EACH CALENDAR YEAR. SUPPLEMENTAL COVERAGE MAY PAY THE DEDUCTIBLE BUT IF NO SUCH COVERAGE IS AVAILABLE THE PATIENT IS REPONSIBLE FOR THE DEDUCTIBLE.
4. MEDICARE PAYS FOR 80% OF ALLOWED CHARGES. SUPPLEMENTAL COVERAGE MAY PAY THE 20%, BUT IF NO COVERAGE IS AVAILABLE, THE PATIENT IS RESPONSIBLE.
5. MEDICARE DOES NOT PAY FOR MAINTENANCE CARE (WELLNESS CARE). THIS WILL BE YOUR RESPONSIBILITY.
6. MEDICARE DOES NOT PAY FOR ALL OF YOUR CHIROPRACTIC CARE COSTS. THE FACT THAT MEDICARE DOES NOT PAY FOR A PARTICULAR ITEM OR SERVICE DOES NOT MEAN THAT YOU SHOULD NOT RECEIVE IT.

| MEDICARE PAYS FOR: | MEDICARE DOES NOT PAY FOR: |
|---|---|
| -Manual manipulation of the spine | -Examinations |
| -If supported by X-RAY and/or EXAMINATION | -X-Rays |
| -After the deductible is met | -Nutritional supplements |
| -Depending upon the condition | -Orthopedic supplies |
| | -Maintenance care (Wellness Care) |
| | -Rehab |

If you have questions regarding these guidelines, please ask, we are here to help you!

I have read and understand the limitations of my Medicare coverage and agree to personally responsible for the payment of non-covered services if I choose to receive those services.

_____

Signature of patient or person acting on patient's behalf Date