Myers Chiropractic Clinic

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INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First MI)_____ **Preferred Name**: _____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home:_____ **Mobile:**_____ **Mobile Carrier:**_____ **Work:** _____

Email:_____ **Gender:** M / F **Marital Status:** Married / Other / Single

Social Security #:_____ **Date of Birth:** _____

Student Status: Full Student / Part Student / Non-Student • **Employed** **Employer:** _____

***Referred By:** _____

Ethnicity: Hispanic or Latino / Other **Preferred Language:** _____

Race: Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ **Previous Chiropractic:** _____

Home:_____ **Mobile:**_____ **Primary Care Physician:** _____

Relationship: Child / Parent / Spouse / Other: _____ **Doctor's Phone:** _____

FINANCIAL INFORMATION

• Insurance • Worker's Comp • Self-Pay (Cash) • Personal Injury/Auto • Other (please explain):_____

PRIMARY INSURANCE

Name:_____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name:_____ **Gender:** M / F

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone:_____ **Date of Birth:**_____

SECONDARY INSURANCE

Name:_____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name:_____ **Gender:** M / F

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone:_____ **Date of Birth:** _____

Who is responsible for payment? Self / Other - *(Relationship)* _____

Other than Self:
Full Name:_____ **Phone:** _____

Address:_____ **City:**_____ **State:**_____ **Zip:** _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient No: _____

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Began When?_____/_____/_____**Describe how this began:**_____

_____

_____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)*_____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both *Leg* - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm – Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area:* _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition? *(Describe)* _____

For this CURRENT condition, have you:

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other:_____**Where?** _____
- **Had any previous Surgery or Interventions in this area?** *(Describe)*_____
- **Taken any Medications?** OTC / Prescriptions _____
- **Had any diagnostic testing?** X-rays / MRI / CT / Other:_____**When and Where?** _____

Describe any Secondary Complaints: _____

HEALTH HISTORY – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)*

Medications:

Allergies to Medications: ***NONE*** *(List)* _____

_____

Current Medications: ***NONE***
*(Already have a list? We can make a copy.)*_____

_____

_____

_____

_____

Past Health History: *(Please list any past…)*

Surgeries – Date, Type, and Reason: ***NONE***

_____

_____

_____

Major Injuries/Traumas: ***NONE*** _____

_____

_____

_____

Major Hospitalizations: ***NONE*** _____

_____

Family Health History:

List *relevant* major health problems of immediate relatives:

_____

_____

_____

Deaths in immediate family: *(Cause and at what Age?)*

_____

_____

_____

Social and Occupational History:

Level of Education Completed: _____

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: *(Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)*

_____

_____

_____

Habits:

Cigarettes – *(#/day)* _____

Alcohol – *(amount/day)*_____

Coffee/Tea – *(cups/day)*_____

Rec. Drugs *(List)*_____

Patient No: _____

REVIEW OF SYSTEMS

Are you *currently* experiencing any of these symptoms? *(Circle all the apply)*
Many of the following conditions respond to Chiropractic treatment.

General: *(constitutional)*
- Recent Weight Change
- Fever
- Fatigue
- *None in this Category*

Musculoskeletal:
- Low Back Pain
- Mid Back Pain
- Neck Pain
- Arm Problems _____
- Leg Problems _____
- Painful Joints
- Stiff/Swollen Joints
- Sore/Weak Muscles or Joints
- Muscle Spasms/Cramps
- Broken Bones_____
- Other: _____
- *None in this Category*

Neurological:
- Numbness or tingling sensations
- Loss of Feeling
- Dizziness or light headed
- Frequent or Recurrent Headaches
- Convulsions or seizures
- Tremors
- Stroke
- Have you ever had a head injury?
- Ever been in an auto accident?
- Other: _____
- *None in this Category*

Mind/Stress:
- Nervousness
- Depression
- Sleep Problems
- Memory Loss or Confusion
- Other: _____
- *None in this Category*

Genitourinary:
- Sexual Difficulty
- Kidney Stones
- Burning/Painful Urination
- Change in force/strain w Urination
- Frequent Urination
- Blood in Urine
- Incontinence or Bed Wetting
- Other: _____
- *None in this Category*

Gastrointestinal:
- Loss of Appetite
- Blood in Stool
- Change in Bowel Movements
- Painful Bowel Movements
- Nausea or Vomiting
- Abdominal Pain
- Frequent Diarrhea
- Constipation
- Other: _____
- *None in this Category*

Cardiovascular & Heart:
- Chest Pains
- Rapid or Heartbeat changes
- Blood Pressure Problems
- Swelling of Hands, Ankles, or Feet
- Heart Problems
- Other: _____
- *None in this Category*

Respiratory:
- Difficulty Breathing
- Persistent Cough
- Coughing Blood
- Asthma or Wheezing
- Lung Problems
- Other: _____
- *None in this Category*

Eyes and Vision:
- Wear contacts/glasses
- Blurred or double vision
- Glaucoma
- Eye disease or injury
- Other: _____
- *None in this Category*

Ears, Nose and Throat:
- Bleeding gums / mouth sores
- Bad Breath or bad taste
- Dental Problems
- Swollen throat or voice change
- Swollen glands in neck
- Ringing in the ears
- Ear - Ache/Ringing/Drainage
- Sinus / Allergy problems
- Nose Bleeds
- Hearing Loss
- Other: _____
- *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- Thyroid problems
- Diabetes
- Excessive Thirst or urination
- Cold Extremities
- Heat or Cold intolerance
- Change in hat or glove size
- Dry skin
- Glandular or hormone problem
- Swollen Glands
- Anemia
- Easily Bruise or Bleed
- Phlebitis
- Transfusion
- Immune system disorder
- Other: _____
- *None in this Category*

Skin and Breasts:
- Rash or Itching
- Change in Skin Color
- Change in hair or nails
- Non-healing sores
- Change of appearance of a mole
- Breast Pain
- Breast Lump
- Breast Discharge
- Other: _____
- *None in this Category*

Women Only:

Are you pregnant?
- **Yes -** ***Due Date*** ____/____/____
- **No -** ***Last Menstrual Period***

  ____/____/____
- Infertility
- Painful or Irregular periods
- Vaginal Discharge
- Other: _____
- *None in this Category*

Pregnancies with Outcome & Date:

_____

_____

_____

Comments: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature_____Date_____

Patient No: _____

Welcome to Myers Chiropractic Clinic!

HIPAA Notice:
I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, 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 a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

Patient's Signature: (parent if minor) _____ Date: _____

Informed Consent for Chiropractic &/or Massage Treatment:
I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or of said minor) by Myers Chiropractic Physiciansand/or its employees. 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, stroke, dislocations and sprains. In the practice of massage there are some risks to treatment, including but not limited to minor bruising, minor pain orsoreness, or nausea**.** I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wishto rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest. I understand that results are not guaranteed. 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 and for any future condition(s) for which I seek treatment.

Patient's Signature: (parent if minor) _____ Date: _____

Medicare Consent for Chiropractic Treatment:
We are a participating office with Medicare, as a Medicare patient you must meet a $185.00 yearly deductible, for medical expenses. Spinal X-rays are **not** reimbursable in a Chiropractic setting, and are your responsibility (but **maybe** covered by your secondary). Medicare will pay 80% of spinal adjustments and you will be responsible for the 20% copay, if you have a secondary we will bill for that amount and they **may** cover. Medicare requires that you have a medical necessity for your spinal adjustment, we can not see you for maintenance, if it is maintenance you will be charged the cash rate of $41.00 and that manipulation will not be billed to Medicare. If Medicare denies payment, for any reason, I agree to be personally and fully responsible for payment. I am requesting and consenting to chiropractic adjustments and treatments, on me (or of said minor) by Myers Chiropractic Clinic physicians.

Patient's Signature: (parent if minor) _____ Date: _____

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Financial Policy

Dear Patient:

Thank you for choosing us as your health care provider. The following is a description of our financial policy:

- Payment for services is due at the time services are rendered.
  - We accept cash, checks, Visa, MasterCard, Discover, and American Express.
  - We will be happy to assist you with applying for financing should you so desire. We do not handle any financing “in house” but we do have financing available through Care Credit.
  - We reserve the right to collect before services are rendered.
- All charges are your responsibility whether the insurance company pays or not.
  - Not all services are a covered benefit. Benefits may vary on different insurance plans. It is your responsibility to verify your insurance coverage.
  - Fees for non-covered services, deductibles, and co-payments are due at the time of treatment.
  - If your insurance company does not pay your claim within a reasonable time frame, or if coverage for a particular service and or supply is denied, we may require you to follow up with your insurance and/or pay the balance due.
- Unless you are insured by Medicare or an insurance group which our doctors are participating members, or double insured (for procedure being performed), it is our policy to collect 100% payment at the time the services are rendered.
- If you are a member of an HMO or Managed Care Program or have a PCP (Primary Care Physician), you are responsible for contacting your PCP for a referral number prior to your visit if one is required by your agreement with your insurance company.
- We understand that temporary financial problems may affect timely payment of your balance. We ask that you speak with our Office Manager, Jeanna M. if you encounter such problems, so that we may assist you in the management of your account. You may reach an Account Manager at (269) 964-1441.

Again, thank you for selecting us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

_____ _____

Patient’s or Guarantor’s Signature Date

_____ _____

Witness Signature Date

Patient No: _____

Patient Name: _____ Date:_____

Appointment Reminders and Health Care Information Authorization

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders/information and understand that…

(Please place a line through any method that you REFUSE to be contacted by and initial.)

I may be *contacted* by:	phone at home or work, mobile phone, e-mail, or postcard. Email: _____
Messages may be left:	on answering machine/voicemail at home, work, and on mobile phone. Or with *individuals answering my phone* at home, or at work.

Information that we use or disclose based on this authorization may be subject to re-disclosure by anyone who has access to the reminder or information and may no longer be protected by the federal privacy rules.

You may restrict the individuals or organizations to which your health care information is released, or revoke your authorization at any time; however, the revocation must be in writing and will become effective once we receive the revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

I authorize the use or discloser of my health information as described above. This notice is effective as of the date below and expires seven years from the date I last received services in this office.

_____ _____
Patient Signature Authorized provider representative

_____ _____
Personal representative Printed Personal representative signature

_____
Description of personal representative's authority to act for the patient.