ProAdjuster Chiropractic Clinic

Please list all of your doctors- fill out as much as you can below

It is extremely important that your doctors receive your office notes to coordinate your treatment.

General Physician
Doctor's first and last name:
Office number (If known):

OB Gynecologist
Doctor's first and last name:
Office number (If known):

Podiatrist
Doctor's first and last name:
Office number (If known):

Dentist
Doctor's first and last name:
Office number (If known):

Psychologist
Doctor's first and last name:
Office number (If known):

Other
Doctor's first and last name:
Office number (If known):

Rheumatologist
Doctor's first and last name:
Office number (If known):

I give authorization to The ProAdjuster Chiropractic Clinic to release my health care information to the above doctors

Print name:_____ **Date:**_____

Sign name: _____

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PATIENT NAME: _____

DATE: _____

ACTIVITY INTAKE FORM

When at its <u>WORST</u> how does your problem affect your daily activities?

	N/A	Painful (Can Perform)	Painful (Limited)	Unable to Perform
DAILY LIVING				
BENDING				
CLIMBING STAIRS				
FALLING ASLEEP				
KNEELING				
LIFTING				
LOOKING OVER SHOULDER				
LYING DOWN				
RISING OUT OF CHAIR				
SITTING				
STANDING				
STAYING ASLEEP				
WALKING				
CARING FOR INFIRM FAMILY MEMBER				
CHILD CARE				
COMPUTER USE (EXTENDED TIME)				
COMPUTER USE (SHORT TIME)				
CONCENTRATING				

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	N/A	Painful (Can Perform)	Painful (Limited)	Unable to Perform
DRIVING				
HOUSEWORK				
LIFTING CHILDREN				
LIFTING/CARRYING GROCERIES				
PET CARE				
READING				
SEXUAL ACTIVITY				
YARD WORK				
DESK WORK				
USING THE TELEPHONE				
BATHING				
DRESSING				
HAIR CARE				
SHAVING				
EXERCISE				
GOLF				
NEEDLE WORK				
PIANO				
RUNNING				
SOFTBALL				
SWIMMING				
TENNIS				

OTHER:

_____

_____

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Patient Intake Form

Patient Information

Date: _____

How did you hear about us? □ Dr. _____ □ Family _____ □ Work □ Yellow pages

□ Drove by □ Friend _____ □ Co-Worker _____ □ Internet

□ Insurance Plan □ Other _____

Title: □ Mr. □ Ms. □ Mrs. □ Miss □ Dr. Single/Married/Divorced/Widowed/Separated

Full Name: _____
First MI Last

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

Age: _____ Birth Date: _____ Female: _____ Male: _____

Social Security Number: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Payment Information

Who Is Responsible For Your Bill? YOU and… [mark appropriate box(es)] □ Myself ONLY OR
□ Worker's Comp □ Health Insurance □ Auto Insurance □ Medicare □ Medicaid □ Other (be specific):_____

Insurance Information

Do you have health insurance? _____ Yes _____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

What is you race? (Please Circle One)
White Black or African American Asian Hispanic or Latino Not Hispanic or Latino
American Indian or Alaska Native Native Hawaiian or other Pacific Islander Other More than one race

What is your preferred language?
English Spanish French German Italian Russian Portuguese
Chinese Japanese Korean Vietnamese

What is your preferred method of communication for private health data? (Please circle one)
Home Phone Work Phone Mobile Phone Email Standard Mail

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Workers Compensation Injury / Auto / Personal Injury:

Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Have you filed an injury report with your employer? □Yes □ No Date:___/___/_____Time: _____am/pm

Carrier: _____ Policy # _____

Carriers Phone #: (_____) _____-_____ Adjuster: _____

Claim #: _____

Current Health Condition

Unwanted Condition (Why you are here today?):_____
When did this Condition BEGIN? _____/_____/_____
Has it ever occurred before? □ Yes □ No. When? _____
Is the Condition: □ Auto Related □ Job Related □ Home Injury
□ Slip or Fall □ Lifting □ Slept Wrong □ Unknown Cause □ Other

Explain: _____

_____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____

_____

Past Health History

Previous Care for Same Condition: □ I have not seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? □ Yes □ No. If yes, Who? (Name) _____

Type of Treatment: _____Was the treatment beneficial in resolving condition? □ Yes □ No

Explain: _____

_____

Previous Chiropractic Care: □ I have not previously seen a Chiropractor OR Fill in the information BELOW.

Type of treatment: _____

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

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Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication (prescription & over the counter)	**Dosage**	**For What Condition?**	**How long have you been taking this?**
Medication- Allergies			
Supplements			

Health Questionnaire

Patient Information

List any surgeries or hospitalizations you have had complete with the month and year for each:

_____

_____

_____

List any medications you are allergic to: _____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you and the individual):

_____

_____

_____

Do you exercise? □ Yes □ No Hours per week _____What activity(s)? _____

_____

Are you dieting? □ Yes □ No Since:_____ Do you smoke? □ Yes □ No _____packs per day.

How many years have you been smoking? _____ Do you drink alcoholic beverages? □ Yes □ No _____drinks per day.

Do you wear? □ Heal lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, How many weeks? _____

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Date of last menstrual period: _____

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
○	○	Abdominal Pain	○	○	Elbow/upper arm pain	○	○	Liver/Gall Bladder Disorder
○	○	Abnormal Weight gain/loss	○	○	Epilepsy	○	○	Loss of Bladder Control
○	○	Allergies Headache	○	○	Excessive thirst	○	○	Low back pain
○	○	Angina	○	○	Frequent Urination	○	○	Mid back pain
○	○	Ankle/foot pain	○	○	General Fatigue	○	○	Neck pain
○	○	Arthritis	○	○	Hand pain	○	○	Painful Urination
○	○	Asthma	○	○	Heart attack	○	○	Prostate Problems
○	○	Bladder Infection	○	○	Hepatitis	○	○	Shoulder pain
○	○	Birth Control Pills	○	○	High blood pressure	○	○	Smoking/tobacco Use
○	○	Cancer	○	○	Hip/upper leg pain	○	○	Stroke
○	○	Chest Pains	○	○	HIV/AIDS	○	○	Systematic Lupus
○	○	Chronic Sinusitis	○	○	Hormone Therapy	○	○	Thoracic Outlet Syndrome
○	○	Depression	○	○	Jaw pain	○	○	Tumor
○	○	Dermatitis/Eczema	○	○	Joint swelling/stiffness	○	○	Ulcer
○	○	Dizziness	○	○	Kidney Stones	○	○	Upper back pain
○	○	Drug/Alcohol Use	○	○	Knee/lower leg pain	○	○	Wrist pain

Additional comments you would like the doctor to know:

_____

_____

_____

Patient's signature: _____Date: _____

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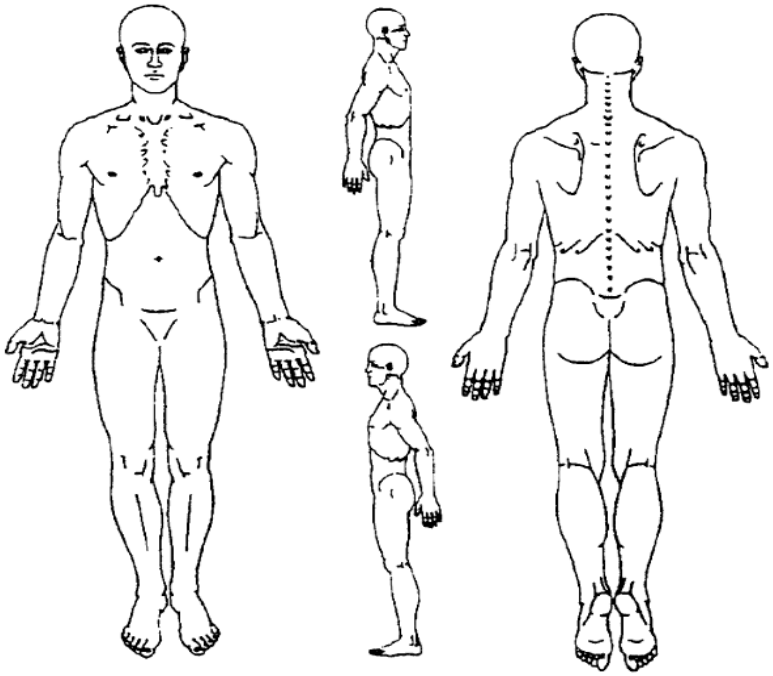
Name:_____ Date:_____

Pain Diagram

Mark the areas on your body where you feel your pain. Include all affected areas. If your pain radiates, draw an arrow from where it starts to where it stops. Use the appropriate symbol(s) listed below.

Ache >>>>> Stabbing ///// Numbness xxxxx

Burning ===== Throbbing ----- Pins and Needles ooooo



Please mark on the line to indicate how severe your pain is at its worst when at **rest.**

No Pain ==========Severe Pain

Please mark on the line to indicate how severe your pain is at its worst when **active.**

No Pain ==========Severe Pain

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ASSIGNMENT OF BENEFITS / HIPAA NOTICE OF PRIVACY PRACTICES

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that the Chiropractic Center of Virginia Beach will prepare any necessary reports and forms to assist me in making collection from my insurance company and that amount authorized to be paid directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, fees for professional services rendered to me will immediately be due and payable.

Should the undersigned default under their terms, and this account referred to an attorney for collection, then the undersigned promise and agrees to pay attorney fees of 33.5% of the principle amount due and owing when turned over for collection and does further agree to pay interest on the unpaid balance at the rate of 1.5% per month (18% per annum) from the date that said monies became due and payable.

I hereby authorize the Chiropractic Center of Virginia Beach to examine and treat my condition as deemed appropriate. The patient also agrees that she/he is responsible for all bills incurred at this office. In the event this matter is turned over for collection, I hereby expressly give permission for my current employer(s) to provide verification of my said employment to this office, or their attorney, Tiffany & Tiffany, P.L.L.C.

Notice of Privacy Practices

In accordance with the Protected Health Information Act (PHI) our office will, without asking your express consent or authorization, use and disclose your PHI for the purposes of:

Treatment
Payment
Health Care Options
Advice of Appointments and Services
Directory/Sign-In Log
Court Orders, Subpoenas and Government Investigations
Advise Family/ Friends directed by you to receive information regarding your health or to assist in the payment of your bill.

You have the right to revoke, request special limits or conditions, to receive communication by more confidential means or at alternate locations, to inspect and copy your PHI, and to amend your PHI.
Our office strives to maintain HIPAA compliance. I understand that by signing the above statement I have been notified of my rights in compliance with HIPPA regulations. I have been advised that I may request a complete copy of these rights available through the HIPAA officer at this location.

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Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

_____ _____

Patient Date

_____ _____

Policyholder/Insured Date

_____ _____

Guardian (if minor) Date

Signature of Authorizing Care

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Appointment Policy

WE RESPECT YOUR TIME AND YOUR BUSY LIFE!!! Our office sees over 98% of our patients on time. If you are running late, ie (stuck in traffic) please call the office. If you are running more that 10 minutes late we probably will not be able to see you. I understand that if I miss an appointment without calling, I will be charged a $35.00 service fee.

Please make sure that you fill out your paperwork and bring it with you for your next appointment. Extra time is not allotted and we may not be able to see you otherwise.

Name (Signed)_____

Name (Printed) _____

Date _____