Office Use Only: BP:_____ HR:_____

Confidential Patient Case History_____H:_____W:____

Name _____Age_____ Birthdate_____

Address_____ City_____ State_____ Zip Code_____

Phone: (H)_____ (W)_____ (C)_____ SS N#_____

Marital Status: □ M □ S □ D □ W Ages of children_____ Email_____

Employer_____ Occupation_____

Do we have permission to text you? _____ Who is your mobile network provider? _____Who *referred* you to us? _____

□ Website □ Magazine □ Drive by □ Phonebook □ Radio □ TV □ Newspaper □ Insurance □ Company

□ Other _____

Insured's name (as it appears on insurance card) _____

Insured's address (if different than above) __ _____

Insured's SSN _____ Insured's DOB _____ Gender: □ Male □ Female

Insured's relationship to patient _____ Insured's employer_____

Emergency contact_____ Phone number_____ Relationship to patient_____

Please describe your major complaint.

_____

_____

How long have you had this condition? _____

List any other doctors seen for these problems. _____

Does this interfere with your normal living, work, and/ or sleep? □ Yes □ No In what way?_____

Have you lost any days of work? □ Yes □ No Dates_____

Have you had similar symptoms or injuries before? □ Yes □ No If yes, explain_____

What do you think caused this condition? _____

What functions are you unable to perform or induce pain upon performance?

List in order of severity:

(ex. Sitting, bending, walking)

1._____ 2._____

3. _____ 4._____

Social Habits

Alcohol

___Does not drink alcohol

___Social drinker

___Light (1-2 drinks daily)

___Moderate (2-3 drinks daily)

___Heavy (3-5 drinks daily)

___Alcoholic (more then 5 drinks daily)

___Recovering alcoholic

Smoking

___Does not smoke cigarettes

___Social Smoker

___Light (less than a pack a day)

___Heavy (a pack a day or more)

Coffee/Caffeine

___Does not drink caffeine

___Drinks an occasional amount of caffeine

___1 cup of caffeine per day

___2 to 4 cups of caffeine per day

___5 or more cups of caffeine per day

Drugs

___Does not use recreational drugs

___Light use of recreational drugs

___Moderate use of recreational drugs

___Heavy use of recreational drugs

___Drug addicted

___Recovering drug addict

Exercise Habit

___None

___Daily

___Every other day

___Few times a week

___Once a week

___Almost nothing

What type of exercise?_____

_____

Work Habits

___Full time

___Part Time

___Homemaker

___Retired

___Unemployed

___Disabled

___Student

-How many hours a week do you work? _____

-What does your job mostly require? (i.e. sitting, standing walking.)_____

-Would you consider it light/ moderate/heavy labor?_____

_____

Personal History

List any allergies?_____

List the medications taken daily?_____

List any surgeries?_____

Last Physicians visit?_____ Who/ Findings?_____

Last Chiropractic visit?_____ Who/ Findings?_____

Personal & Family History

Mark *S for self* and *F* for family

Family History only includes grandparents, parents, and siblings.

___ Aids/ HIV
___Alcoholism
___Allergies
___Alzheimer's
___Anemia
___Anorexia
___Appendicitis
___Asthma
___Autoimmune problems
___Bedwetting
___Bleeding disorders
___Blood clots
___Blurred vision
___Breast lump
___Bronchitis
___Bulimia
___Cancer. What kind?
_____
___Changes in hair/nail color
___Chemical dependency
___Constipation
___Depression
___Diabetes
___Diarrhea
___Dizziness
___Drug addiction
___Ear infections
___Emphysema
___Epilepsy
___Eye problems
___Fainting
___Fibromyalgia
___Fractures. Where?
_____
___Heart disease
___Hepatitis
___Hernia
___Herniated disc
___High blood pressure
___High cholesterol
___Kidney disease
___Liver Disease
___Low blood pressure
___Migraine headaches
___Miscarriage
___Multiple sclerosis
___Osteoarthritis
___Osteoporosis
___Pacemaker
___Parkinson's disease
___Pinched nerve
___Pneumonia
___Polio
___Previous chiropractic care
___Prostate problem
___Psychiatric problems
___Rapid Heartbeat
___Rheumatoid Arthritis
___Scoliosis
___Seizures
___Stroke
___Suicide attempt
___Thyroid problems
___Tinnitus
___TMJ Problems
___Tumor
___Ulcers
___Vaginal infections
___Venereal disease
___Vertigo
___Weight gain
___Weight loss
___ Other_____
_____
_____

Patients of Authorized Person's Signature: I Authorize the release of any medical or other information necessary to process my insurance claim.

*Signed:*_____ *Date:*_____

Crum Chiropractic Clinic

FINANCIAL POLICY

We are pleased to accept your insurance assignment subject to verification of your coverage. We will file your claims as a courtesy to you in every way we can. However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.

1. I authorize payment of medical benefits directly to Crum Chiropractic Clinic
2. I authorize the release of any medical information necessary in the processing of my insurance claims.
3. I agree that I will pay the percentage of charges not covered by my insurance company at the time of service. (example: If my insurance pays 80% of my charges, then I pay 20% at the time of charge.)
4. I agree that I will pay in full for charges for items or services which Crum Chiropractic Clinic believes will not be covered by my insurance company at the time they are incurred.
5. I agree that I am totally responsible for any charges in this office and, if for some reason my insurance company does not cover charges within sixty (60) days or a claim is denied, I will pay those charges immediately.
6. I agree that if my insurance company, for some reason, sends the payments to me, I will bring or send those payments to Crum Chiropractic Clinic immediately.
7. I agree that a copy of this document can be considered the same as an original when used for insurance billing purposes.

PLEASE SELECT ONE OF THE FOLLOWING:

___CASH ACCOUNT: You will be required to pay in full for all services rendered upon each visit unless other payment arrangements are made. Itemized statements will be furnished to you upon request. We do not bill your insurance company for cash accounts.

___HEALTH INSURANCE ACCOUNTS: We will bill your insurance for you as long as your insurance company makes payment directly to Crum Chiropractic Clinic. While meeting your deductible, you will be asked to pay the full amount allowed by your insurance company for services rendered. After your deductible has been met, you will be responsible for paying non-covered items at the time they are purchased and for the percentage not covered by your insurance. Verification of your insurance benefits does not guarantee payment. We will bill your insurance company as a courtesy to you and will estimate your portion (the percentage not covered by your insurance) as closely as possible based upon the benefits as explained to us by your insurance company. Crum Chiropractic Clinic will not enter into any disputes with your insurance company.

___WORKER'S COMPENSATION CLAIMS: If you were injured at work and want us to bill your employer's work comp carrier, we may have to get an authorization from the carrier in order to treat you. Please note that under state laws, we may not be authorized to treat you for a work injury. If the work comp carrier denies claims, we will bill you for the charges.

___PERSONAL INJURY OR MOTOR VEHICLE ACCIDENT: If you were injured in a car accident, we will be happy to bill the car insurance once liability has been established. We will wait up to one year from the date of your first visit to receive payment from the liability insurance. After one year has passed without payment in full, you will be responsible for paying your account. If you have med-pay benefits available on your car insurance policy for your injuries, we will bill the med pay also so that we can receive payments on a timelier basis.

MY SIGNATURE BELOW VERIFIES THAT I HAVE READY, FULLY UNDERSTAND AND AGREE TO THE ABOVE OFFICE POLICIES AND WILL ALLOW CRUM CHIROPRACTIC CLINIC TO ACCEPT MY INSURANCE ASSISGNMENT IF APPLICABLE.

SIGNATURE OF RESPONSIBLE PARTY DATE

NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. Any specific written authorization you provide may by revoked at any time by writing to us.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. The provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice at any time, provided that the changes are permitted by law. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

If you have any questions about this notice or feel that we may have violated your privacy rights, please contact us.

For additional information go to www.hhs.gov and search HIPAA.

My signature below verifies that I have read and fully understand this notice.

_____ _____

Patient Signature Date

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I hereby consent to the performance of examination and treatment by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists that may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment, based upon facts known, that is in my best interest.

I further understand that there are certain degrees of risk associated with the chiropractic adjustment or other clinical procedures. This includes, rarely, but not limited to, fractures, disc injuries, strokes and strain/sprains and I am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

_____ _____

Patient's Name (Print) Patient's Signature

_____ _____

Date Relationship to Patient

(FOR FEMALE PATIENTS ONLY.)

I do hereby state that to the best of my knowledge, I am NOT pregnant, nor is pregnancy suspected or confirmed at this particular time. _____ (initial here)

Date of last menstrual cycle _____

I do hereby state that to the best of my knowledge, I am pregnant, or pregnancy is suspected.

Expected Due Date _____

_____ _____

Patient's Name (Print) Patient's Signature

_____ _____

Date Relationship to Patient