Hicks Chiropractic Health Center Patient Intake Form

Name: ____
Address:____________________________ City:_______________________________________
State: ________________________________Zip:__________ Home Ph: ____________________________
Work Ph:_____________________ Cell: ________________________ Email:______________________
Social Security#________________ DOB:____________________________________ Gender: ***M F***
Occupation: _________________Spouse's name:____
Children (name and age) ____
Whom May We Thank for Referring? ____

Have you been to a Chiropractor? YES NO

List symptoms you are experiencing **today**: Choose the severity level associated with each symptom

____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Frequency of Pain ❑Occasional ❑Intermittent ❑Frequent ❑None

Type of Pain ❑Aching ❑Burning ❑Dull ❑Pulling ❑Sharp ❑Shooting ❑Stabbing ❑Stinging ❑Throbbing ❑None

____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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Are your present problems due to an injury? ❑Yes ❑No Enter the date of the onset: ________________________________

How do you think your problem began? ❑ Job Related □Auto Accident □Personal Injury ❑Other: _______________________

Briefly describe the accident, injury or illness:____

____

____

Auto Accident Only

Driver of other vehicle (if any)____

Liable Insurance: ____

Insurance Claim Contact (Name and Number): ______________________________

Policy #: ____________________________Claim # :______________________

Name of driver in vehicle in which you were injured (self or other): ______________________

Other Insurance: ____

Policy #: ____________________________ Claim #:______________________

Have you retained an attorney? ***Yes*** ***No*** ***Not Yet***

If so please write name, address and phone number:______________________________

List any tests, studies or medications received for this condition:

❑Tests/Studies: ____

❑Medications: ____

Has the accident been reported? ❑Yes ❑No If so, to whom?____________________ ❑Other: ____________________

Where you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? ____________________Transported by? ❑Ambulance ❑Police ❑Other: ____________________

Date Admitted: _______________ Date Released: ____________ Length of Stay: ______________

List the hospital procedures received: ____

List symptoms you experienced after accident: Choose the severity level associated with each symptom

______________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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Do you have any current work restrictions due to this condition?

Off work: ❑Yes ❑No ❑Previously From: ____________________ To: ____________________

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) ______________________________

What type of work do you do?____

____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No _____

_____

List any past conditions you may have had: _____

HABITS

❑Current Every Day Smoker ❑Current Some Day Smoker

❑Former Smoker ❑Never Smoker

❑Drinking Alcohol: (Cups/day): _____ ❑Coffee Cups/Day: _____

❑Soft Drink Bottles or Cans/Day: _____ ❑Water Cups/Day: _____

EXERCISE

❑None

❑Moderate

❑Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑
Father	❑	❑	❑	❑
Sibling(s)	❑	❑	❑	❑

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No

If Yes, please indicate the following:

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

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Discontinued Use: _____

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: _____

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____
Start Date: _____
End Date: _____

Allergy: _____
Reaction: _____

Allergy: _____
Reaction: _____

Start Date: _____ Start Date: _____
End Date: _____ End Date: _____

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE		DATE		DATE	
_____	Back Operation	_____	Hernia	_____	Gall Bladder
_____	Female Organs	_____	Thyroid	_____	Stomach

Other _____

Have you ever had X-rays taken? ❑Yes ❑No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS

- ❑ Allergy(What) ____ _____
- ❑ Bronchitis
- ❑ Chills (Constant)
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel

EYE/EAR NOSE/THROAT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats
- ❑ Tonsillitis

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Prostate Trouble

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Pregnant Now?

❑ Stiff Neck	❑ Slow Heart	❑ Skin Eruptions	_____ Last Pap Date
❑ Spinal Curvature	❑ Strokes		_____ Last Menstrual Cycle
❑ Swollen Joints	❑ Swelling Ankles		

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ Date: _____

HICKS CHIROPRACTIC HEALTH CENTER

Payment and Insurance Policy

Hicks Chiropractic Health Center will try to assist patients in obtaining insurance benefits whenever possible. It must be understood, however, that:

1. **The patient is responsible for full payment of all services rendered on their behalf or on behalf of their dependent.**

2. We will call to verify benefits. **However, we cannot be responsible for errors in the quoting of benefits**. We suggest that you become aware of your own benefits, deductibles, health reimbursement plans, and maximums, etc.

3. **Insurance is a contract between you, the Insurance Company, and/or your employer.** Hicks Chiropractic Health Center is not a party to that contract. Assisting you in trying to obtain payment is a courtesy and may be withdrawn at any time.

4. Insurance carriers are billed weekly by Hicks Chiropractic Health Center. Insurance payments are generally received within 30 days. The maximum time limit that Hicks Chiropractic Health Center extends is 60 days. Thereafter the patient must pay the fees in full.

5. Patients must stay current with the full amount of their percentage of responsibility (e.g. if the insurance is expected to pay 80% of the bill, the patient must pay at least 20% of the charges). This must be paid at least weekly.

6. If the patient discontinues care for any reason other than discharge by the doctor, the patient must pay the outstanding balance in full, immediately—regardless of any claims submitted.

7. If the patient fails to keep regular appointments, they will be discharged. The patient must pay the outstanding balance in full, immediately

8. All deductible amounts must be paid prior to submission for insurance benefits.

9. If there is any balance due after the Statement of Benefits is received from the insurance carrier, that balance is due from the patient immediately.

10. If the patient fails to pay off the balance due or make payments, the account will be turned over for collections after 60 days of non-payment. The patient will also be responsible for any collection fees acquired in the collection process.

11. Any refunds made to patients will be based on the full account balance, without presuming further insurance benefits that may be payable.

I have read, understand, and agree to the above. Furthermore, I hereby authorize and request that insurance companies pay directly to Hicks Chiropractic Health Center any insurance benefits for chiropractic care, health-related service, and durable medical equipment that would otherwise be payable to me.

Name: _____ **Date**_____

HICKS CHIROPRACTIC HEALTH CENTER

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Hicks Chiropractic Health Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

"*On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Hicks Chiropractic Health Center."*

"It is our policy to provide a substitute health care provider, authorized by Hicks Chiropractic Health Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

"*As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Hicks Chiropractic Health Center for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposes of fundraising purposes, as described below: (example)

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time or your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

"It is our practice to participate in charitable events to raise awareness, food donation, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Hicks Chiropractic Health Center sponsored fund-raising events."

Change of Ownership

In the event that Hicks Chiropractic Health Center is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights:

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however that Hicks Chiropractic Helath Center is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Fountain of Life Chiropractic amend your protected health information. Please be advised, however, that Hicks Chiropractic Health Center is not required to agree to amend your protected health information. If your request to amend you health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Hicks Chiropractic Health Center.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Hicks Chiropractic Health Center reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Hicks Chiropractic Health Center is required by law to comply with this Notice.

Fountain of Life Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact our office at (816)741-4711.

Complaints

Complaints about your Privacy rights or how Hicks Chiropractic Health Center has handled your health information should be directed to our office by calling (219) 879-2177.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights

200 Independence Avenue, S.W.

Room 509F HHH Building

Washington, DC 20201

This notice is effective April 14, 2003.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Hicks Chiropractic Health Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____

Patient's Name (print)

_____ _____

Patient's Signature Date

_____ _____

Authorized Facility Signature Date