

Family Chiropractic Center of Sanford

1100 Carthage Street
Sanford, NC 27330
(919) 775-2114 (919) 776-4032

Date: _____

Full Name: _____ Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

SS# _____ Date of Birth: _____ Age: _____ Ethnicity: _____

Driver's License # _____ Marital Status: S M D W
(circle one)

Occupation: _____ Company Name: _____

Company Address: _____

Spouse's Name: _____

Spouse's employer: _____ Phone: _____

Insurance Company: _____ Attorney: _____

Insured's Name: _____ Insured's DOB: _____

Present Complaints: _____

Date of onset: _____

Have you seen any other Doctor for this condition? Yes No If yes, Who? _____

Have you missed any work due to this condition? Yes No From _____ to _____

How did you hear about our office?

Contact in case of emergency: _____ Relation: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Please turn this sheet into the Front Desk along with your current insurance information and a photo id.

QUICKCHARTS PATIENT CASE HISTORY



Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____

Email Address: _____ Occupation: _____

Date of Birth: _____ Social Security #: _____ - _____ - _____ Gender: Male - Female

List any Allergies:

- Animals Aspirin Bees Chocolate Dairy Dust Eggs Latex Molds Penicillin
- Ragweed/Pollen Rubber Seasonal Allergies Shellfish Soaps Wheat X-Ray Dye
- Other: _____

List any Surgeries:

- Back Brain Elbow Foot Hip Knee Neck Neurological Shoulder Wrist
- Other: _____

List ALL Past Medical History conditions:

- Ankle Pain Arm Pain Arthritis Asthma Back Pain Broken Bones Cancer Chest Pain
- Depression Diabetes Dizziness Elbow Pain Epilepsy Eye/Vision Problems Fainting
- Fatigue Foot Pain Genetic Spinal Condition Hand Pain Headaches Hearing Problems
- Hepatitis High Blood Pressure Hip Pain HIV Jaw Pain Joint Stiffness Knee Pain
- Leg Pain Menstrual Problems Mid-Back Pain Minor Heart Problem Multiple Sclerosis
- Neck Pain Neurological Problems Pacemaker Parkinson's Polio Prostate Problems
- Shoulder Pain Significant Weight Change Spinal Cord Injury Sprain/Strain Stroke/Heart Attack
- Other: _____

List Type of Medications you are taking:

- Anxiety Muscle Relaxors Pain Killers Insulin Birth control Cardiovascular Allergy Seizure
- Other: _____

List your **Family History**:

- Arthritis Asthma Back Pain Cancer Depression
- Diabetes Epilepsy Genetic Spinal Condition
- High Blood Pressure Heart Problems Multiple Sclerosis
- Neurological Problems Parkinson's Polio
- Prostate Problems Stroke/Heart Attack
- Other: _____

Main reason for consulting the office:

- Become pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity level

Have you had any auto or other accidents? No Yes

Describe: _____

Date of last physical examination: _____ Do you smoke? No Yes

Do you drink alcohol? No Yes - how many per day? _____

Do you drink caffeine? No Yes - how many per day? _____

Do you exercise? No Yes (what forms and how often): _____

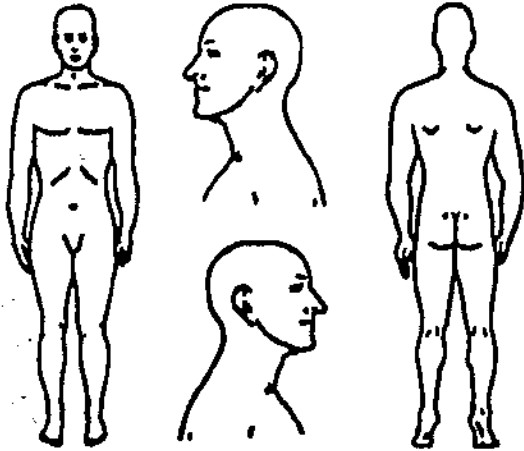
COMPLAINTS

Family Chiropractic Center
1100 Carthage Street Sanford, NC

Patient Name: _____

Date: _____

PLEASE MARK YOUR AREAS OF PAIN BELOW



What is your major complaint? _____

Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

- Constantly (76-100% of the day) Frequently (51-75% of the day)
 Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Describe the nature of your symptoms:

- Sharp Dull Numb Burning Shooting Tingling Radiating Pain
 Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

- 1 2 3 4 5 6 7 8 9 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

HISTORY:

Recent Falls: Y N _____

Recent Surgeries: Y N _____

Recent Accidents: Y N _____

Doctor's Comments: _____

You have the right to inspect and receive a copy of your health information. Further, you have a right to request that Family Chiropractic Center of Sanford amend your health information but they are not required to agree to amend it. If your request is denied, you will be given an explanation of denial reasons and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your health information made by Family Chiropractic Center of Sanford.

Family Chiropractic Center of Sanford is required by law to maintain the privacy of your health information. If you have any questions regarding this notice, you may contact the Privacy Officer by calling (919) 775-2114. If you need to make an appointment with the Privacy Officer you may do so by telephone or in person. If you are not satisfied with the way your complaint is handled, you may request the address to file a formal complaint.

If you witness any perceived discrepancy or possible violation concerning HIPAA, you must report it to the Privacy Officer.

We must disclose your health information to DHHA as necessary for them to determine our compliance with HIPAA standards.

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

I provide Family Chiropractic Center of Sanford with my authorization and consent to use my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Printed Patient Name or Guardian Name

Signature of Patient or Guardian

Date

I authorize release of any medical information or other information necessary to process any claim.

Signature of Patient or Guardian

Date

Further, I authorize payment of medical benefits for services rendered be made payable to Family Chiropractic Center of Sanford.

Signature of Patient or Guardian

Date

Authorized Office Signature

Date

Family Chiropractic Center of Sanford

1100 Carthage Street
Sanford, NC 27330
(919) 775-2114 (919) 776-4032

Family Chiropractic Center of Sanford is required by law and in compliance with HIPAA to maintain the confidentiality of your protected health information and to provide patients with notice of privacy practices with respect to health records.

We may disclose healthcare information to other healthcare professionals within our practice for the purpose of treatment and healthcare. It is our policy to provide another healthcare provider for your treatment during our absence.

We may disclose your health information to your insurance company for the purpose of payment. As a courtesy, we will submit an itemized statement to your insurance company for the purpose of payment for services rendered. These itemized statements include diagnosis, date of injury or condition, codes describing services rendered and charges.

Health information for patients treated under Worker's Compensation may be disclosed as necessary to comply with State Workers' Compensation Laws.

We may disclose health information to another healthcare provider in response to your referral to or from our office.

We may contact you by mail or e-mail to provide appointment reminders or information about treatment, alternate treatment or other health benefits, birthday cards, holiday cards, periodic announcements and services that may be of interest to you.

In emergencies, we may disclose your health information to notify or assist in notifying a family member or other individual responsible for your care.

As required by law, we may release health information to public health authorities for purposes of preventing or controlling disease, injury or disability, reporting child abuse or neglect, domestic violence and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding, law enforcement official, complying with a court order or subpoena or other law enforcement purpose.

As a courtesy, we may call your home or leave a message, starting your next appointment date and time or missed appointments. No personal health information will be disclosed.

Your name can be listed on our Birthday Board and/or our Superstar Referral Board.

You have the right to request restriction on certain uses and disclosures of your health information. If you have such a request, please notify Family Chiropractic Center of Sanford immediately with the restrictions.

disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers.
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Austin and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Dated: _____

Patient's Name

Doctor's Name

Signature

Signature

Signature of Parent or Guardian
(if a minor)

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Informed Consent to Chiropractic Treatment

Patient Name: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- | | | |
|--|---|---|
| <input type="checkbox"/> spinal manipulative therapy | <input type="checkbox"/> palpation | <input type="checkbox"/> vital signs |
| <input type="checkbox"/> range of motion testing | <input type="checkbox"/> orthopedic testing | <input type="checkbox"/> basic neurological testing |
| <input type="checkbox"/> muscle strength testing | <input type="checkbox"/> postural analysis | <input type="checkbox"/> EMS |
| <input type="checkbox"/> ultrasound | <input type="checkbox"/> hot/cold therapy | |
| <input type="checkbox"/> radiographic studies | | |
| <input type="checkbox"/> Other (please explain) | | |

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous

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I _____ confirm that the complaints I have today and for
(print name)

which I am seeking treatment, are not connected with or arising from any work or

employment related injury: related to any type of personal injury involving a third party

insurance company or an attorney; or is in relationship with any possible disability claim.

I further state that I will not be billing any worker's compensation carrier, an attorney or

a third party payer for any bills that I incur at Family Chiropractic Center of Sanford.

(Signature)

(Date)

Authorization and Assignment

To: Dr. Skip Austin, D. C.

In consideration of your undertaking to treat me, I agree to the following:

Authorization to Release Information

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

Assignment of Cause of Action

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is/are believed to correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe you, and agree to pay in a current manner.

Authorization to Pay Directly to Doctor

To: _____
(Name of attorney and/ or insurance company)

In consideration of the chiropractic services rendered and to be rendered by him I authorize and direct the payment to the doctor named above of any sum I now or hereafter owe him by you, my attorney, out of the proceeds of any settlement of my case, and/ or by any insurance company obligated to reimburse me for the charges for his services or otherwise obligated to reimburse me for the charges for his services or otherwise obligated to make payment to me or him based in whole or in part upon the charges made for his services.

Acknowledgement and Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services at the Family Chiropractic Center of Sanford office, and that I have been advised that the doctor(s) providing the services is/ are willing to wait for payment for these services, provided that these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either:

- (1) That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor(s) or make other provisions for the protection of the interest of the doctor(s); or
- (2) If a liability claim exists, or my attorney refuses to agree to protect the interest of the doctor(s), or if I have not engaged the services of an attorney;

Then payment for services rendered by the doctor(s) at the Family Chiropractic Center of Sanford office will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever comes first.

Patient's Signature

Date

Witness

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To All New Patients

All insurance will be requested to be made out and mailed to Family Chiropractic Center of Sanford. This includes health insurance, med-pay insurance and the other person's liability insurance. If your expenses at FCC are overpaid, you will be reimbursed for the over payment.

Our bill is expected to be paid first from insurance proceeds. We do not expect to be the last one to wait on our bill to be paid. We will work with you on collecting from the insurance companies involved.

This office will be glad to file your claims for you. Please do not send receipts to the insurance company unless you make arrangements with our insurance department first. We will work with you, asking that you pay your deductible and your percentage. Remember, you are responsible for any amount your insurance does not pay.

Personal Injury: If you engage an attorney to handle your case, (and we do encourage you to engage an attorney) all information will be sent directly to the attorney upon a written request from him stating that he is representing you. No information will be given out concerning your case (not even to you) except directly to your attorney.

We are on computer, and all insurance information must be put in within the first day or two, or the computer will print a claim. If after several days you remember that you have insurance you would like to file with, there will be a \$5.00 fee.

There will be a \$5.00 fee on all disability forms that you need to have filled out by this office.

Medicare Patients: We are sorry, but we do not accept assignment on Medicare. The patient must pay us and we will be glad to file all your claims and have the insurance company to send the check to you.

Appointments: The doctor will make a schedule concerning the appointments that he believes is necessary in making you well again. You are expected to keep these appointments as scheduled. Please call if you are unable to keep an appointment. If you do not call or show up within 30 minutes of you appointment, you will be called. This puts extra work on us which is unnecessary. If you do not show up for an appointment and we are unable to contact you within 10 days, you will be terminated from our care. Your case will be closed and all paperwork sent to the proper insurance company.

Signature

Date