BERGTOLD CHIROPRACTIC

PATIENT INFORMATION

NAME_____ DOB_____ DATE _____

ADDRESS_____CITY_____STATE_____ZIP_____

MOBILE PHONE _____-_____-_____ WORK PHONE _____-_____-_____

HOME PHONE_____-_____-_____ EMAIL:_____

HEIGHT_____WEIGHT_____ ☐ FEMALE ☐ MALE

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

SPOUSES NAME:_____

EMPLOYER_____WORK PHONE_____POSITION_____

HOW DID YOU HEAR ABOUT US? ☐INTERNET ☐SOCIAL MEDIA ☐WORD OF MOUTH

☐OTHER _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT:_____

RELATIONSHIP:_____ PHONE:_____-_____-_____

INSURANCE INFORMATION

DO YOU HAVE INSURANCE? ☐ YES ☐ NO

INSURANCE NAME _____ PHONE _____-_____-_____

ADDRESS _____ CITY_____ STATE _____ ZIP_____

ID/POLICY NUMBER:_____ GROUP NUMBER:_____

INSURED NAME: _____ INSURED D.O.B:_____

HEALTH HISTORY:

PLEASE LIST ANY AND ALL
CONDITIONS_____

LIST OF ALL MEDICATION YOU ARE CURRENTLY
TAKING_____

WOMEN: DATE OF L.M.P_____PREGNANT?_____ NURSING?_____

BIRTH CONTROL?_____ SMOKE?_____HOW MANY A DAY?_____ DO YOU DRINK?_____

WHAT EXERCISE DO YOU DO?_____

REASON FOR VISIT:

MAIN COMPLAINT: _____

WHEN DID IT START?_____

IS THIS CONDITION CAUSED DUE TO A/AN : ☐AUTO ACCIDENT ☐WORK INJURY
☐OTHER_____

WHAT POSITION OR ACTIVITY IS WORSE?_____

WHAT POSITION OR ACTIVITY MAKES YOU FEEL BETTER? _____

IS THE PAIN GETTING WORSE?_____

LIST ANY SURGICAL PROCEDURES:_____

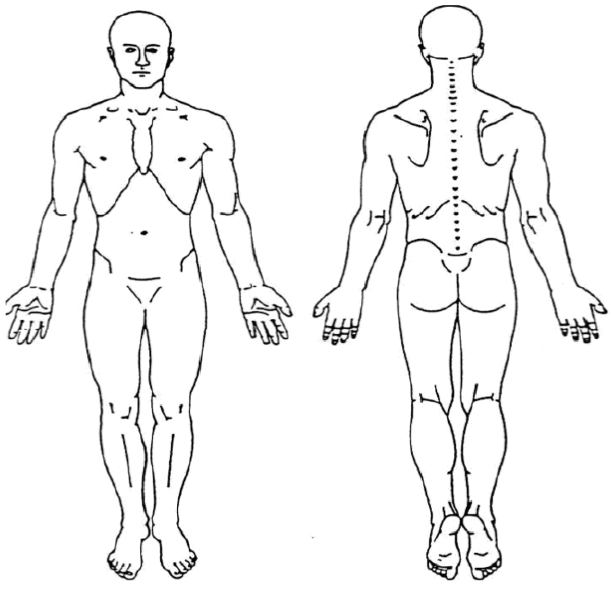
<u>On the body diagrams to the right, please indicate your areas or symptoms by drawing in the appropriate symbols.</u>

P-pain

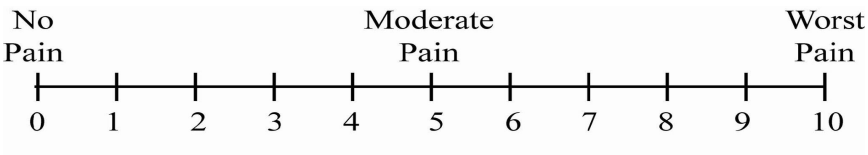
N-numbness

S-shooting

A-aching



PAIN SCALE:



HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of health and human services. www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than the office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or adverting of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,(PRINT NAME)_____(SIGNATURE)_____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

INFORMED CONSENT TO TREATMENT

*ALL ABOVE QUESTIONS HAVE BEEN ANSWERED ACCURATELY, AND I UNDERSTAND THAT GIVING FALSE OR INCORRECT INFORMATION can be dangerous. I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursements of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care for treatment.

By signing below, I, the undersigned patient (authorized representative) consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures including lab and radiographic studies, as ordered by the office and its healthcare providers.

Patient Signature:_____ Date:____-____-_____

Print Name:_____

*Patients with health plans present your insurance ID cards to the receptionist after completing this form.

ASSIGNMENT OF BENEFITS

I, hereby authorize Bergtold Chiropractic, and its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I authorize the release and disclosure of any or all of my, or my childs, medical records to any other entity including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment for the patient. I authorize this office and its/or its employees to release, via fax or other secure source to receive or send medical records in which are needed to receive the best care.

Patient Signature:_____ Date:____-____-_____

Print Name:_____