Chiropractic Case History

Date _____

Name _____ Age ____ Birth Date _____
Address _____
City _____ State _____ Zip code _____
E-Mail Address _____
Cell Phone _____ Cell Phone Provider _____
Race _____ Marital Status: M S W D Number of Children _____
How were you referred to us? _____

Work Information:
Occupation _____ Employer _____

Emergency Information
Emergency Contact _____ Relation _____
Cell Phone _____

Health History:
What brings you into our office today? (Chief Complaint)
_____

***Date your current condition began: _____**
Is your condition due to: **Work** **Auto Accident** **Trauma** **Other**
Please Describe Cause of Complaint _____
_____
Have you ever experienced these symptoms before? **Y/N**
If so, when? _____
Have you been treated by any other healthcare provider within the past year? **Y/N**
If so, for what reason? _____
Do you currently have any significant health related issues or diseases? **Y/N**
Please list: _____
What surgeries have you had? (Please provide approx. dates):
_____
List any broken bones or dislocations (Please provide approx. dates):
_____
What medication(s) are you currently taking?
_____
What nutritional supplement(s) are you currently taking?
_____
How would you describe your overall health? **Excellent** **Good** **Fair** **Poor**
Do you feel you are as healthy now as you were 5 years ago? **Y/N**
If not, why? _____
Women only*: *To the best of your knowledge, are you currently pregnant? Y/N

Past Chiropractic History:
Have you ever been to a chiropractor before? Y/N
If so, for what condition(s)_____
When was your last adjustment? _____ Chiropractor's Name _____
What is your medical doctor's name? _____

OVER→

About Your Current Condition: **Name** _____

1. Please List Your Current Complaint(s):

A. _____ (Chief Complaint)
B. _____
C. _____
D. _____

2. Please rate your discomfort level:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Excruciating Pain)

3. Is your condition: **Worsening** **Staying the Same** **Getting Better**

4. How frequent is it? **Constant** **Frequent** **Intermittent** **Occasional**

5. Can you think of any other conditions, which may be related to your complaints? Y/N

Please describe _____

6. Describe the pain:

Sharp **Dull** **Numb** **Tingling** **Achy** **Burning**
Stabbing **Throbbing** **Traveling** **Other** _____

7. What makes your condition better? _____

8. What makes your condition worse? _____

9. What is the primary goal of your care with our office? (Please check ***one*** answer)

- ❑ Temporary Pain Management
- ❑ Correction and Stabilization of Your Condition
- ❑ Improve Overall Health
- ❑ Decrease Dependency on Medication
- ❑ Preventative Wellness Care

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Authorization and release: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable and this office reserves the right to charge interest on any unpaid balances.

By signing below, the patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your healthcare information will be used by this office and your rights in regards to your records. If you would like a more detailed account of our policies and procedures concerning the privacy of your records, we encourage you to read the HIPAA notice that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your records, please inform our office.

Patient/Guardian Signature _____ Date _____

OVER→

Pain Disability Rating Scale

(Adapted from Rowland Morris Disability Questionnaire)

Patient Name _____ Date _____

When you are in pain, you may find it difficult to do the things you normally do. This list contains some sentences people have used to describe themselves when they have pain. When you read them, you may find some of them stand out because they describe you today. *When you read a sentence that describes you*, mark the box next to it. **If the sentence does *not* describe you today, then leave the box next to it blank and go on to the next one.**

- ☐ I stay at home most of the time because of my pain.
- ☐ I change position frequently to try to get comfortable from my pain.
- ☐ I walk more slowly than usual because of my pain.
- ☐ Because of my pain, I am not doing some of the jobs that I usually do around the house.
- ☐ Because of my pain, I have to use a handrail to go up the stairs.
- ☐ Because of my pain, I lie down to rest more often.
- ☐ Because of my pain, I ask other people to do things for me.
- ☐ I get dress more slowly than usual because of my pain.
- ☐ I only stand up for short periods of time because of my pain.
- ☐ Because of my pain, I try not to bend or kneel down.
- ☐ I find it difficult to get out of a chair due to my pain.
- ☐ I hurt most of the time.
- ☐ I find it difficult to turn over in bed due to my pain.
- ☐ My appetite is not very good because of my pain.
- ☐ I have trouble putting on my socks because of my pain.
- ☐ I only walk short distances because of my pain.
- ☐ I sleep less because of my pain.
- ☐ Because of my pain, I need someone to help me get dressed.
- ☐ I sit down for most of the day because of my pain.
- ☐ I avoid heavy jobs around the house because of my pain.
- ☐ Because of my pain, I am more irritable and ill-tempered around people.
- ☐ Because of my pain, I go up stairs more slowly than usual.
- ☐ I stay in bed most of the day because of my pain.
- ☐ I have difficulty sweeping or vacuuming because of my pain.
- ☐ My pain makes doing my hair difficult.
- ☐ I have difficulty reaching for objects on high shelves due to my pain.
- ☐ I have difficulty sitting for long periods of time due to my pain.
- ☐ I cannot easily get up from the floor due to my pain.

Pain Drawing

Patient Name: _____ Date: _____

Date of Birth: _____

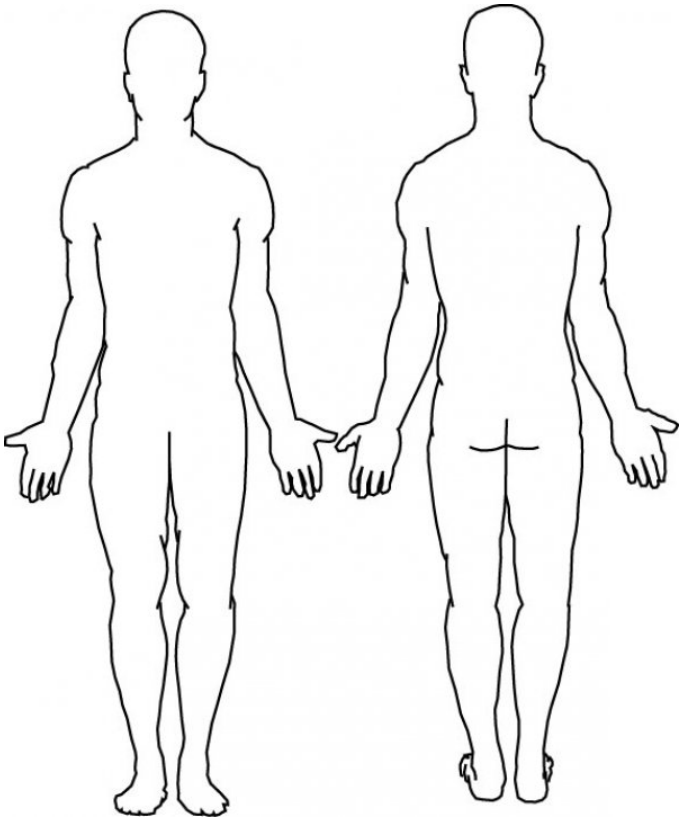
TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel pain. Include ALL affected areas. Mark areas of radiating pain. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below:

Ache: > > > > > Numbness: = = = = = Pins & Needles: o o o o o

Burning: x x x x x Stabbing: / / / / / Throbbing: ~ ~ ~ ~ ~



Front Back

Patient Informed Consent

Patient Name _____ Date _____
Address _____ City _____ State ____ Zip _____
Age _____ Date of Birth _____ Social Security # _____

I hereby request and/or consent to the performance of chiropractic adjustments and/or other chiropractic procedures, on me (or on the patient named above for whom I am legally responsible) by Dr. Nance and/or those whom he may designate as his assistant/associate.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to chiropractic care, including but not limited to remote possibility of stroke, sprains and strains, fractures, dislocations, and general aggravations of inflammatory conditions. I understand that I will have the opportunity to discuss with the doctor and/or assistant the nature and purpose of the chiropractic procedures I will receive. I understand that the doctor will perform an examination in order to minimize any risks of care, however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor and/or associate to exercise judgment during the course of the procedure which the doctor and/or associate feels at the time, based on the facts known, is in my best interest.

I also understand that, as with any healthcare procedure, there are no guarantees of results with chiropractic treatment and realize that some patients will respond more favorably to care than others. I further realize that there is a small possibility that my condition may not improve by conservative means but, nonetheless, authorize the doctor and/or associate to utilize his/her judgment and experience in the treatment of my condition to the best of their ability given my current health status. To that end, the doctor and/or associate are authorized to employ those practices and procedures, which he/she feels are reasonable and necessary to resolve my condition.

Finally, I understand that, while a third party provider may attempt to dictate a treatment protocol or regimen to the doctor and/or associate, the doctor and/or associate will provide me the treatment needed, be it more or less, regardless of third party re-imbursement or approval. Reasonableness and necessity of treatment will instead be based on current chiropractic research, expected outcomes, and acceptable standards of care. Should care be necessary beyond that which is approved by third party re-imbursement, I understand that I am ultimately responsible for any balance incurred at Advantage Chiropractic Clinic, LLC dba San Tan Chiropractic and will make attempts to resolve those balances promptly.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the procedures. I intend this consent form to cover the entire course of care for my present condition(s) and for any future condition(s) for which I seek care.

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Signature Date

Missed Appointment Policy

Our office depends on the reliability of our patients to keep their appointments, not only to ensure we are able to see our patients as they require, but to ensure that our patients are consistent with their care. While we do provide a courtesy reminder call for our patients the business day before their next visit, it is ultimately the **responsibility of the each patient to remember their appointment**.

In an effort to minimize last minute cancellations and maximize appointment availability for all of our patients, we reserve the right to charge a **$40 missed appointment fee for any missed appointment without a 24-hour notice**. Please remember that we have reserved a time slot especially for you and turn other patients away from that slot when it is reserved

*We truly respect our patient's **valuable** time.* Please appreciate that *our time* is also valuable by giving us reasonable notice if you intend to cancel or reschedule.

Insurance Collection Policy

Almost all insurance companies require some form of out of pocket amount that the patient must pay for their care, usually in the form of a deductible, co-pay, or co-insurance amount, which is due at the time services are rendered. In fact, with the exception of personal injury and workers compensation claims, **no health insurance covers 100% of your care**. Moreover, in an age of increasing deductibles, third party insurance is ever more likely to offer fewer benefits for chiropractic services.

While many offices may waive or write off these patient responsibilities, it must be noted that the routine waiver of a deductible or co-pay, regardless of whether the provider is contracted or not, is a form of **fraud** known as *inducement*. **Our office does not and will never participate in insurance fraud.**

We will make every attempt to collect the patient's responsibility at the time of service for any services we do not expect your insurance to cover. Our office will be happy to process your insurance claim on your behalf and accept direct assignment with your insurance. While our goal is to verify your insurance benefits, **verification is not a guarantee of coverage** and we cannot guarantee that the information we are provided by your insurance is accurate. Unfortunately, your insurance company has the ultimate say in what they agree to cover or not but please remember that ***you are ultimately responsible for any bill or charges with our office***. Any non-covered services, denied services, or those applied to a deductible or co-pay, are the ultimately the responsibility of the patient. That being said, we don't want finances to be a detriment to your health. Please notify our staff immediately if you have any financial concerns with may impact your care.

I HAVE READ AND UNDERSTAND THE ABOVE OFFICE POLICIES

Signature _____ Date _____

Notice of Privacy Practices

We are required by law to maintain the privacy of your health information as outlined in the Health Insurance Portability and Accountability Act (HIPAA), which took effect April 14, 2003. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. Other than the uses and disclosures we describe below, we will not sell or provide any of your health information to any outside marketing organization.

We must abide by the terms of this notice while it is in effect, but reserve the right to change the terms of our privacy notices. If we make a change, it will apply to all of your health information in our files, and we will attempt to notify you if/when you come in for treatment.

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.

Any correspondences should be addressed to: **Advantage Chiropractic Clinic, LLC dba San Tan Chiropractic**
1900 W. Germann Rd. #16
Chandler, AZ 85286

Uses and Disclosures: We may use and disclose information about you for treatment, payment, and other healthcare operations. For Example:

- We may need to disclose your health information to another healthcare provider or physician providing treatment.
- We may disclose examination, treatment, and billing records to another party (i.e. your insurance company, billing service, collection agency, state and federal agencies)
- We may need to use any information in your file for quality control purposes or other administrative purposes to run our practice.
- We may need to use your name, address, phone number, e-mail, and clinical records to contact you for the purposes of appointment reminders, information regarding your treatment, or follow-up post-treatment. We may also use this information to contact you regarding other health information and alternatives that may be of interest to you (i.e. lab tests, x-ray findings, etc.). If you are not at home to receive an appointment reminder, a message may be left on your answering machine, voicemail, e-mailed, or texted to you.
- We may use your name and information to provide you with in-office promotions and other miscellaneous offers. Please let us know in advance if you do not want to receive notifications from our office.

You have the right to refuse to give us authorization to contact you regarding your treatment at this office. If you choose not to authorize our office, it will not affect the treatment provided to you or the methods we use to obtain reimbursement for services rendered, including billing you by mail or collection proceedings. You may inspect or copy the information that we use to contact you regarding your care at any time.

Your right to limit uses or disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations and we will make every attempt to honor this request. Please submit this request in writing. In certain circumstances, however, we may have to release your information without your consent. This may include release to governmental agencies via subpoena, for collection proceedings or billing purposes, or if we feel that your health may be at risk should we withhold critical health information. We will notify you if we must disclose your information against a specific written request not to do so.

Permitted uses and disclosures without your consent and authorization: Under federal law, we are permitted or required to disclose your health information without your consent or authorization in the following circumstances:

- We are providing healthcare services to you based on the referral of another healthcare provider.
- We provide healthcare services to you in an emergency and we are unable to obtain your consent after attempting to do so.
- There are substantial barriers to contacting you, but believe in our professional judgment we believe that you intend for us to provide care.

Revoking your authorization: You may revoke your authorization to us at any time in writing, with three circumstances under which we will not be able to honor your revocation request:

- If we have already released your health information before we receive the revocation.
- If you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to review your health information if they decide to contest your claim.
- If your records were requested via subpoena.

Treatment: This office utilizes an "open-therapy" environment for ongoing patient care. This concept may involve several patients being seen in the same therapy room at the same time. Patients will be within eyesight of one another and ongoing routine details are discussed within earshot of other patients and staff. This environment is generally used for on-going care and NOT, as a rule, for taking patient histories, providing examinations, or presenting a report of your findings. These procedures are provided in a private examination room. Chiropractic adjustments will be administered in either a private room, an adjusting room that does have a door with a glass insert, or in the open therapy bay. The purpose of our open and private treatment areas is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality care. If you choose not to be treated in an open-therapy environment, other arrangements will be made for you.

Amending your health information: You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information ins in our files. We require a written request to amend your records that includes a valid reason to support the change. We reserve the right to refuse any unsubstantiated, inaccurate, or nonfactual request.

Inspecting or copying your health information: You have the right to inspect the health information contacted in your files in our office or have copies made for you. The health information contained in your file is available up to seven years from the date that the record was created or as long as the information remains in our files. **Your request must be in writing** to inspect the records and/or have them copied. The State of Arizona does not allow us to charge a fee for copying records when the request is for the purposes of continued healthcare. However, our office does reserve the right to charge a reasonable fee for record requests made for the purposes of non-healthcare related needs to cover our administrative costs in fulfilling this request. This may include but is not limited to insurance requests, attorney requests, or other requests made to necessitate the settlement of a claim. While the information contained on x-rays is yours, the films themselves are the property of our office and are part of your healthcare record. You may check your films out at any time but request that you return your original films within 30 days.

Accounting of disclosures of your records: You have the right to request an accounting of any disclosures made of your healthcare information for up to six years prior to the date of your request. This request must be in writing. The accounting may exclude the following disclosures:

- Disclosures required for your treatment to obtain payment for services, to run our practice, and/or made to you.
- Disclosures necessary to maintain a directory of individuals in our facility or to individuals involved in your immediate care.
- Disclosures for national security, intelligence purposes, or to local or federal law enforcement.
- Disclosures that were made prior to the effective date of HIPAA privacy law (April 14, 2003)

We will provide the first accounting of the past 12 months for no charge but any additional requests will be charged a reasonable fee to offset our administrative costs in fulfilling your request. You will be made aware of the fee for this request in advance and given the opportunity to withdraw or modify your request.

Re-Disclosure: We cannot control the actions of others to whom we have released your information for treatment. Information that we use or disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by federal privacy rules.

Complaints: You have the right to file a complaint with the privacy officer or with the Secretary of the Department of Health and Human Services if you believe we have violated your privacy rights. Written comments should be addressed to our office or Secretary of Health and Human Services, 200 Independence Ave., S.W. Room 509F, HHH Bldg, Washington, D.C., 20201. We respect your right to file a complaint and will not take any action against you.

This notice is effective April 14, 2003.

Printed Patient's Name: _____

Patient/Guardian Signature: _____

Date: _____