NEW PATIENT PAPERWORK FOR INSURANCE OR CASH

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Welcome to Our Office

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your health information to:

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Discuss your case with family
- Do research
- Include you in care classes
- Thank you for referring other patients

We may use your health information for:

- Health and safety reasons
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings
- Reporting to worker's compensation

You have the right to:

- Request a copy of your health record
- Request a list of whom we share your health information with
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated
- Request confidential communications
- Amend your protected health information

These privacy practices are effective: ____________________

For further information please contact: ____________________

Consultation & Exam

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests.

If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition.

We will always inform you of associated fees before we perform any procedure or service.

Report of Findings

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination.

If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short and/or long-term goals.

As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy
- I understand the purpose of today's visit
- The doctor(s) may use my confidential health information in the manner previously described

____
patient or guardian signature

____
date

PATIENT INFORMATION FORM

(Office use only)

1)New patient_______ Previous Patient (New Case) ____________

Patient Code#________________ 2) Date: ___/___/_____ 3) Time ___:___ __m 4) Claim#___________________

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5) First Name: ________________________ M.I. ____ Last Name: ____________________________ 6)Sex: 1) Male 2) Female

7)Birthdate_____/_____/_______ Age_______ Marital Status (S M W D) Spouse's Name_________________________________

8) Social Security # _______/____/__________ 9) Home Phone ( ) ____ - ________ Cell Phone( ) ____ - ____________

10) Address ____ City _______________________ State _______Zip ________

11) Employer ____ 12) Job Title ____________ Work Phone ( ) _____- __________

Driver's License No. ________________________________ State: ___________

Person Responsible for this account ____

Referred By ____

Primary Insurance: (Group___ Work/Comp ____ Automobile ___ Other ___) 13) Policy # ____________________________

Insurance Co. ____ 14) Group# __________________________

Address ____ City ________________State _____ Zip ______ Phone ( )____-__________

15) Primary name of Insured: _____________________DOB:____/____/_____ Relationship to Patient _________ SS#____________

16) Employer _________________________________ Employee # _________________________ Work Phone ( )______-__________

Work Address____ City ________________ State: _________ Zip_________

Secondary Insurance: (Group___ Work/Comp ____ Automobile ___ Other ___) Policy # ____________________________

Insurance Co. ____ Group# __________________________

Address ____ City ________________State _____ Zip ______ Phone ( )____-__________

Primary name of Insured: _____________________DOB:____/____/_______ Relationship to Patient _________ SS#____________

Employer _________________________________ Employee # _________________________ Work Phone ( )______-__________

Work Address____ City ________________ State: _________ Zip_________

Other Insurance: (Group___ Work/Comp ____ Automobile ___ Other ___) Policy # ____________________________

Insurance Co. ____ Group# __________________________

Address ____ City ________________State _____ Zip ______ Phone ( )____-__________

Primary name of Insured: _____________________DOB:____/____/_______ Relationship to Patient _________ SS#____________

Employer _________________________________ Employee # _________________________ Work Phone ( )______-__________

Work Address____ City ________________ State: _________ Zip_________

Are you or do you think you might be pregnant? 1) Yes 2) No

17) Cause of complaint: (circle) 1) Auto Accident 2) Work Injury 3) Other Accident 4) Illness 5) Congenital 6) Unknown

I Understand and agree that health and accident insurances polices are an arrangement between an insurance carrier and me. I authorize payment for my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney's fees as may be required to effect collection.

Patient Signature ____ Date______/______/__________

PATIENT HEALTH HISTORY

Name: ________________________________ **Family Physician:** _________________________

1) FAMILY HISTORY: (Circle as many as apply)

MOTHER: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

If deceased- Age at death: _____

FATHER: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

If deceased- Age at death: _____

SIBLINGS: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

2) SOCIAL HISTORY:

MARITAL STATUS: 1) Single 2) Married 3) Divorced 4) Widowed

NUMBER OF CHILDREN: (1) (2) (3) (4) (5) (6) (7) (8) (None)

DO YOU: 1) Exercise regularly 2) Eat a balanced diet 3) Obtain sufficient rest

DO YOU SMOKE? 1) No 2) Less than 1 3) 1-2 4) 2-3 5) 3-4 6) More than 5 (packs / day)

DO YOU DRINK COFFEE/TEA? 1) No 2) Occasionally 3) 1-2 4) 2-3 5) 3-4 6) More than 5 (cups / day)

DO YOU DRINK ALCOHOL? 1) No 2) Occasionally 3) 1-2 4) 2-3 5) 3-4 6) More than 5 (drinks / day)

3) MEDICAL HISTORY:

CHILDHOOD ILLNESSES: 1) Measles 2) Mumps 3) Chickenpox 4) Tuberculosis 5) Rheumatic fever 6) Diabetes

LIST ANY SERIOUS CHILDHOOD ILLNESSES NOT RECORDED ABOVE.

____ Age: [ ]

____ Age: [ ]

____ Age: [ ]

LIST ANY BIRTH DEFECTS:

____

HOSPITALIZATIONS & SURGERIES: If you have ever been hospitalized, list reason and dates.

________________________________ M/D/Y____/____/______

________________________________ M/D/Y____/____/______

________________________________ M/D/Y____/____/______

ADULT ILLNESSES/INJURIES: List all serious diseases & injuries for which you have not been hospitalized; include approximate dates.

________________________________ M/D/Y____/____/______

________________________________ M/D/Y____/____/______

________________________________ M/D/Y____/____/______

4) MEDICATIONS:

List all medications that you are currently taking or have taken on a regular basis in the last 6 months (include home remedies).

A) ______________________ B) ______________________

C) ______________________ D) ______________________

MEDICATIONS IN WHICH YOU ARE ALLERGIC:

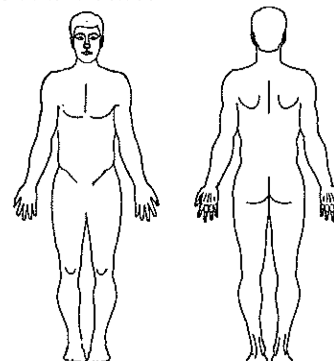
A) ______________________ B) ______________________

C) ______________________ D) ______________________

INITIAL HEALTH STATUS
Chiropractic

Patient Name______________________________ Birthdate________________ Sex: M / F
Address______________________________ City______________________
State________ Zip____________ Phone (___)____________ Patient Primary Language______________
Occupation________________ Employer____________________ Work Phone____________
Address______________________ City________________ State________ Zip__________
Subscriber Name______________________ Health Plan______________________
Subscriber ID #______________ Group #______________ Spouse Name______________
Spouse Employer________________ City________________ State________ Zip__________
Primary Care Physician Name______________________________ PCP Phone______________

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

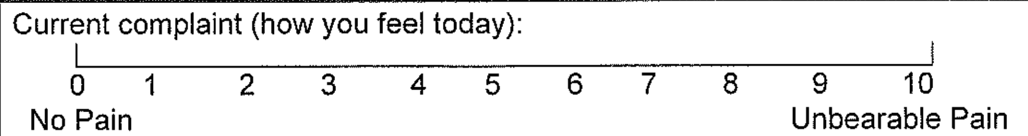
☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other______________________________

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began______________________________

How Problem Began

Current complaint (how you feel today):



How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken________________ **What areas were taken?**________________

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)________________
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)________________
____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)____________
☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks__________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries________________
____
☐ Tobacco Use - Type______________
Frequency______________/Day
☐ Medications________________

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature______________________________ **Date**________________

Authorization to Use or Disclose Protected Health Information

Cheeley Chiropractic, Inc.
900 East Washington St., Ste 300
Colton, CA 92324
Phone: (909) 533-4591 Fax: (909) 533-4597

Patient Name:____

Address:____

Date of Birth:________________________**Date Requested:**__________________

As required by the Privacy Regulations, Cheeley Chiropractic, Inc. may not use or disclose your protected health information except as provided in or Notice of Privacy Practices without your authorization.

I hereby authorize Cheeley Chiropractic, Inc. and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), and/or business associates of this office:

____

Patient Health Information authorized to be disclosed:

____

For specific purpose of (describe in detail):

____

Effective dates for this authorization: ________________ through__________________
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond the control of Cheeley Chiropractic, Inc.

I understand I have the right to:

1. Revoke this authorization by sending written notice to Cheeley Chiropractic, Inc. and previous reliance on the used or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under Federal Law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not affect my condition, my treatment, payment, enrollment in a health plan, or eligibility for benefits, whether or not I provide authorization to use or disclose protected patient health information.

____ __________
Signature of Patient or Patient's Authorized Representative **Date**

____ __________
Authorized Signature of Facility **Date**

Assignment and Instruction for Direct Payment to Doctor
Private and Group Accident and Health Insurance

Patient Name:____

Name of Employer:____

Claim/Group #:____

SS#/ID#:____

I hereby instruct and direct the ______________________________ insurance Company

to issue check made out and mailed directly to:

Cheeley Chiropractic, Inc.

900 East Washington St., Ste 300
Colton, CA 92324

If my current policy prohibits direct payment to doctor, I hereby instruct and direct you to make out the check to me and mail it as follows:

C/O Cheeley Chiropractic, Inc.

900 East Washington St., Ste 300
Colton, CA 92324

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner and any balance of said professional service charges over and above the insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated at ____________________ this ______ day of ____________ 20 ______

____ ____________
Signature of Patient or Patient's Authorized Representative **Date**

____ ____________
Authorized Signature of Facility **Date**