Welcome

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____ _____

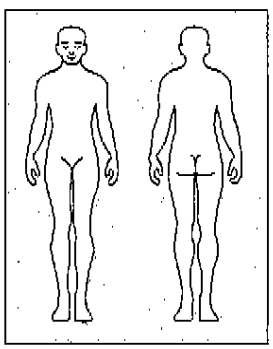
Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

– O V E R –

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other_____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsilitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Other_____		
			Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day_____
- ☐ Alcohol — Drinks/Week_____
- ☐ Coffee/Caffeine Drinks — Cups/Day_____
- ☐ High Stress Level — Reason_____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy Name_____		
Pharmacy Phone (_____)_____		

Whole Health Chiropractic

HIPAA Acknowledgement

(Please print)

Name: _____ **Date of Birth:** _____

Mailing Address: _____

At which of the following phone number(s) do we have permission to contact you?

- ○ Home _____ May we leave a message for you at home?
  □ Yes □ No
- ○ Cell _____ May we leave a message for you on your cell?
  □ Yes □ No
- ○ Work _____ May we leave a message for you at work?
  □ Yes □ No
- ○ Other _____ May we leave a message for you at this number?
  □ Yes □ No

Other than you or your insurance company, whom may we speak to about your healthcare information?

- ○ Spouse Name/Telephone _____
- ○ Child Name/Telephone _____
- ○ Parent Name/Telephone _____
- ○ Caretaker Name/Telephone _____
- ○ Other Name/Telephone _____

Do you have any health information that you would like to be kept confidential from any of the people you have listed? □ Yes □ No
If so, please describe below:

_____

_____

I acknowledge that I have been given the opportunity to request restrictions on the use and/or disclosure of my protected heath information.

I acknowledge that I have been given the opportunity to request alternative means of the communication of my protected health information.

I acknowledge that I have read and signed a copy of the Privacy Notice for Whole Health Chiropractic.

_____ _____
Patient or Personal Representative Signature Date

_____
Relationship to Patient

Whole Health Chiropractic Notice of Privacy Practices

We understand that treatment information about you and your health is personal. We are committed to protecting information about you. This notice briefly describes how treatment information about you may be used and disclosed.

We are required by law to:

- Make sure that treatment information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to treatment information about you; and
- Follow the terms of the notice that is currently in effect.

We may use treatment information about you to provide you with treatment or services. We also may disclose information about you to people outside the clinic who may be involved in your care, such as family members or others we use to provide services that are part of your care.

We may use and disclose treatment information about you so that the treatment and services you receive at the clinic may be billed to and payment may be collected from you, your insurance company, or a third party.

If you are involved in a lawsuit or a dispute, we may disclose treatment information about you in response to a court or administrative order. We may also disclose treatment information to a subpoena, discovery request, or other lawful process by someone else involved in the dispute as required by federal, state or local law.

You have the right to inspect and copy treatment information that may be used to make decisions about your care, usually, this includes treatment billing records. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of treatment information about you.

You have the right to request a restriction or limitation on the treatment information we use or disclose about you for treatments, payment, or health care operations. In your written request, you must tell us (1) what information you wanted limited; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example disclosure to your spouse.

You have the right to request that we communicate with you about your treatment matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

If you have any questions or concerns about your treatment in regard to our policies, would like to inspect a complete copy of this document, obtain copies of your treatment information, or restrict disclosure of your treatment information, please contact us at 972-530-2273.

_____

Print Name

_____

Patient Signature Date

We reserve the right to change this notice without prior notification to you.

WHOLE HEALTH CHIROPRACTIC
FINANCIAL POLICY

Thank you for choosing Whole Health Chiropractic (WHC) for your chiropractic care. We are committed to providing you with quality health care. Our financial policy is as follows:

• Please note that you will need to present your insurance card and proof of identity (e.g. driver's license) at your first visit. You will be responsible for providing a change of address, telephone number and/or insurance information anytime a change occurs. We accept cash, major credit cards, and debit cards.

I. WHC has provider contracts with some insurance carriers with "in-network" status.

- Insurance contracts require us to collect your co-payment at the time of service.
- Our office will assist you in receiving proper reimbursement by filing your claim promptly.
  - ☐ After your insurance company processes the claim, (in about 30 days) you will receive an Explanation of Benefits (EOB) from your insurance, which will show the "***Patient Responsibility***" amount.
  - ☐ If there is a balance, we will provide you with a statement showing the amount due.
  - ☐ For large balances, you may contact our Billing Department to make payment arrangements using your credit/debit card.

- Individual coverage varies dramatically within our contracts and your coverage is an agreement between you and your health plan/health insurance company.
- It remains your responsibility to verify that the care you receive is covered by your health plan/health insurance.
- This office is not responsible for the expense of treatment not paid by your health plan/health insurance.
- With continuous changes in coverage, you should verify your benefits and understand all requirements of your health plan/health insurance by calling the customer service number on your health plan/health insurance card.

II. When WHC does not have a contract with your health plan/health insurance carrier, services are "Out of Network"

- This means that you may have no insurance benefits with our clinic.
- You will be responsible for the entire amount at the time services are rendered.
- As a courtesy, we can file a claim to your health plan. Should your plan pay, you will be refunded.
- Your signature on this Financial Policy will be your acknowledgement that you are aware that your Benefits will be paid as "out of network".

III. Motor Vehicle Accidents (MVA) & Third Party Liability

- WHC will file claims for services provided as the result of a motor vehicle accident or third party Liability injury; however, the patient will be responsible for the entire account.
- You will be required to complete a special Vehicle Accident Information form before you will be seen by the doctor.
- For Third Party cases, a prepayment of $85 will be required on the initial visit.

IV. Workers' Compensation

• Patients with *authorized* Workers' Compensation will not be subject to this Financial Policy.

V. No Insurance Coverage (self pay)

• The patient or guardian will be responsible for payment, which may include x-rays at the time of service. The Office Visit charge will be $85. There will be an additional charge for x-rays, tape, decompression and other services.

VI. Referrals

• If your health insurance requires a referral from your primary care provider (PCP) for your visit with our practice, the referral must be obtained by the patient and presented to us at the time of the visit. If you do not have the required referral from your PCP, the visit will be re-scheduled to allow time to contact your PCP and arrange for a referral.

I have read the financial policies of Whole Health Chiropractic and accept responsibility for payment of my account.

Patient Name_____ Date of Birth: _____

Responsible Party Signature_____ Date_____