Houston County Chiropractic

2157 Denton Rd
Dothan, AL 36303
(334) 794-4648

Today's Date: ____/____/20____ email: _____

Name: _____ Address: _____

City/State/Zip: _____ Marital Status: S M W D

Home Phone: ( ) _____-_____ Cell: ( ) _____-_____ Work: ( ) _____-_____

Preferred Contact Method (Circle One): Home Work Cell Text E-mail

Date of Birth: ____/____/_____ Age: _____ Social Security #: _____ - ____ - _____

Employer: _____ Occupation: _____

Address: _____ City/State/Zip: _____

Spouse Name: _____ Spouse DOB: ____/____/_____

Please indicate payment type: Cash Check Visa/Master Card/Discover Other

Do you have Health Insurance: Yes No Plan/Group #: _____

Insurance Carrier: _____

Were you referred to our office? Yes No If yes, Who: _____

Please describe the major complaint(s) that brought you in today: _____

_____

Is your complaint due to an injury: Yes No If so, Date of injury: ____/____/_____

Type of Injury: Auto Work Other _____

How does your complaint(s) affect your everyday life? _____

_____

On a scale of 1 to 10 (1=no pain, 10=extreme pain) how would you rate your pain: _____

Have you ever been adjusted by a Chiropractor? Yes No If so when: ____/____/_____

List any medications you're taking: _____

_____

List any past surgical procedures: _____

_____

(over please)

History: Please mark any condition(s) that applies to yourself or a family member.

( ) Allergies	( ) High Blood Pressure	( ) Head Injury
( ) Vision Problems	( ) Hearing Problems	( ) Concussions
( ) Diabetes	( ) Asthma	( ) Heart Problems
( ) Seizures	( ) Cancer	( ) Bowel Problems
( ) AIDS	( ) Anemia	( ) Bladder Problems
( ) Headaches	( ) Numbness/Tingling	( ) Urinary Problems
( ) Sinus Problems	( ) Backaches	( ) Reproductive Problems
( ) Neck Pain	( ) Multiple Sclerosis	( ) Respiratory Problems
( ) Chronic Fatigue	( ) Fibromyalgia	( ) Epilepsy
( ) Spinal Surgery	( ) Psychological Problems	( ) Muscular Dystrophy
( ) Herniated Disc(s)	( ) Digestive Problems	( ) Fainting
( ) Broken Bones	( ) Constipation	( ) Dizziness
( ) Paralysis	( ) Diarrhea	( ) Other _____

Are you interested in:	( ) Lasting Correction	( ) Wellness Care
	( ) Symptom Relief	( ) Family Care

In the event of a scheduling error or unforeseen office closing please list someone we can contact who will always know where to reach you:

Name: _____ Address: _____

Home Phone: ( ) _____-_____ Work: ( ) _____-_____

Patients with Insurance: As a courtesy we will file your insurance for you, although that does not guarantee reimbursement. Ultimately you will be responsible for any outstanding balance if your insurance denies payment for covered or non-covered services rendered in our office. If you have any questions about your financial responsibilities please ask at the front desk prior to seeing the Doctor. We offer flexible payment plans to make it affordable to get the care you need without making it a financial burden. Family plans are also available, so if you're interested please ask at the front desk for more details.

Chiropractic Examination and Analysis: As a part of the examination I consent to the following procedures to determine if Chiropractic care is suitable for my condition.

Vital Signs	Neurological Testing	Range Of Motion Testing
Radiographic Studies	Orthopedic Testing	Palpation
Thermography Scan	Postural Analysis	

Patient's Signature: _____ Date: ____/____/20_____

Spouse or Guardian's Signature: _____ Date: ____/____/20_____

*Payment for services is due each visit unless prior arrangements are made.

NAME_____ **DATE**_____**CASE#**_____

Rand 36-Item Health Survey 1.0

1. In general, would you say your health is:

Excellent.....	1
Very good.....	2
Good.....	3
Fair.....	4
Poor.....	5

2. **Compared to 1 year ago,** how would you rate your health in general **now**?

Much better now than 1 year ago.....	1
Somewhat better now than 1 year ago.....	2
About the same.....	3
Somewhat worse now than 1 year ago.....	4
Much worse now than 1 year ago.....	5

The following items are about activities you might do during a typical day. **Does your health now limit you** in these activities? If so, how much?

CIRCLE ONE NUMBER ON EACH LINE

	Yes Limited a lot	Yes limited a little	No not limited At all
3. **Vigorous activities**, such as running,lifting heavy objects, participating in strenuous sports	1	2	3
4. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	1	2	3
5. Lifting or carrying groceries	1	2	3
6. Climbing **several** flights of stairs	1	2	3
7. Climbing **one** flight of stairs	1	2	3
8. Bending, kneeling or stooping	1	2	3
9. Walking **more than a mile**	1	2	3
10. Walking **several blocks**	1	2	3
11. Walking **one block**	1	2	3
12. Bathing or dressing yourself	1	2	3

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?**

	CIRCLE ONE NUMBER ON EACH LINE		
		Yes	**No**
13.	Cut down the **amount of time** you spend on work or other activities	1	2
14.	**Accomplished less** than you would like	1	2
15.	Were limited in the **kind** of work or other activities	1	2
16.	Had **difficulty** performing the work or other activities (for example it took extra effort)	1	2

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)

	CIRCLE ONE NUMBER ON EACH LINE		
		Yes	**No**
17.	Cut down the **amount of time** you spend on work or other activities	1	2
18.	**Accomplished less** than you would like	1	2
19.	Didn't do work or other activities as **carefully** as usual	1	2

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups?

(circle 1 number)

Not at all..... 1
Slightly..... 2
Moderately..... 3
Quite a bit..... 4
Extremely..... 5

21. How much **bodily** pain have you had in the **past 4 weeks?**

(circle 1 number)

None..... 1
Very mild..... 2
Mild..... 3
Moderate..... 4
Severe..... 5
Very severe..... 6

NAME_____ **DATE**_____**CASE#**_____

22. During the **past 4 weeks,** how much did **pain** interfere with your normal work (Including work outside the house **and** housework)

(circle 1 number)

Not at all..... 1
Slightly..... 2
Moderately..... 3
Quite a bit..... 4
Extremely..... 5

These questions are about how you feel and how things have been with you **during the last 4 weeks.** For each question, please give the 1 answer that comes closest to the way you have been feeling.
How much of the time during the last 4 weeks...

CIRCLE ONE NUMBER ON EACH LINE

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Did you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6

32. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time..... 1
Most of the time.... 2
Some of the time.... 3
A little of the time 4
None of the time.... 5

How TRUE or FALSE is *each* of the following statements for you? **CIRCLE ONE NUMBER ON EACH LINE**

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a lot easier than other people	1	2	3	4	5
34. I am as healthy as anybody I know	1	2	3	4	5
35. I expect my health to get worse.	1	2	3	4	5
36. My health is Excellent.	1	2	3	4	5

Houston County Chiropractic

Statement of Financial Responsibility

Assignment of Insurance Benefits

I hereby authorize payment directly to Houston County Chiropractic of all medical benefits otherwise payable to me on my behalf for the procedure(s) performed at Houston County Chiropractic. I understand any unpaid deductibles, co-pays, or co-insurance amounts not payable by my insurance are my responsibility regardless of any pending insurance amounts. These amounts due from me are due on the date of service. This assignment of benefits is valid for insurance companies and programs, including Medicare.

Authorization of Release of Information

I authorize Houston County Chiropractic to release any and all medical information concerning the treatment performed at Houston County Chiropractic as may be required by my insurance company in order to process payment of my claim(s).

Charges

I understand that standard charges have been established for all services at Houston County Chiropractic, I further understand that the fee(s) for my treatment(s) and the charges will be billed to my insurance company as well.

Credit Policy

Houston County Chiropractic will file the appropriate claim forms to my insurance carrier. I will be notified when the final action (payment, denial, etc.) by my insurance carrier has been received. I understand that if my account becomes delinquent it will be placed with Prim and Mendheim LLC. Further, I agree to the following terms regarding any outstanding balance that I owe: (1) I will incur interest at the rate of 1 & ½ percent per month (18% PER ANNUM); (2) I agree and hereby consent that I will be responsible for reasonable collection costs and attorney's fees in and costs of court incurred by this office in the collection of same, whether such outstanding balance is satisfied prior to, after initiation of a lawsuit, or after a judgement has been issues in a lawsuit; and (3) I agree and hereby consent that any lawsuit and/or legal proceeding surrounding the outstanding balance and debt, and fees and costs thereon, shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and/ or objections to said jurisdiction and waive all rights to claim exemption. By signing below, I consent to the terms contained herein and affirmatively acknowledge that I have read the same before signing. Furthermore, I agree that if a cell phone number has been provided, I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida, I agree to waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance. I also agree that at any time if my balance has not been paid according to policy, I understand my credit history will be investigation and thoroughly reviewed.

I have read and understand the terms of this policy statement.

_____ _____

Patient's Signature (Parent or Guardian if Minor) Date

_____ _____

Signature of Insured if other than Patient Date

Chiropractic Orientation

All new persons in our office are required to attend an orientation on chiropractic within the first two weeks of care. This orientation is intended to give you a better understanding of what chiropractic truly is and what we hope to accomplish during you course of care. Orientations are held every **Monday** from approximately 6:15 to 6:45 p.m. and every **Saturday** from 8:30 to 9:00 a.m. It is strongly recommended that you bring your spouse to the orientation so that they will understand what you will be going through and why they should be checked for a subluxation.

Signature:_____Date:_____

----------Stop----------

Please return this paperwork to the front desk

HOUSTON COUNTY CHIROPRACTIC
HIPAA PRIVACY POLICY
PATIENT CONSENT FORM

Our Promise to You our Valued Patient

We want to assure you that we take the Federal HIPAA (Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our office because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why A Privacy Policy?

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review not only how your information is used within our computers but also with the Internet, phones, fax machines and any device used to copy or transfer this data.

We want to advise you that we have developed policies and procedures for our practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information. We will assure our office adherence to those laws and we want you to understand our procedures and your rights as a valued patient.

Your health information will be communicated only for the purpose of conducting health care business and obtaining payment for services. Be assured that without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used to Provide Treatment

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health professionals providing you treatment.

To Obtain Payment

Your health information may be included with an invoice for the purpose of collecting payment for services provided to you in this office. We may do this with insurance forms filed for you by mail or electronically. We will make every effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care in our office. *As* a result, your health information may be included in the training programs for students, interns, and associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing, or credentialing activities.

Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or members of your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care chiropractic can provide. They may include postcards, newsletters, flyers, and telephone or electronic reminders such as email *(unless you tell us that you prefer not to receive reminders).*

Public Health and National Security

As permitted or required by State or Federal law, we may disclose your health information to proper authorities for the purpose of law enforcement including, under certain circumstances, if you are a victim of a crime or in order to report a suspected crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be assisting you with your home care, treatment or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, if you are unable to tell us what you want, we will use our very best judgment when sharing your health information with anyone participating in your care.

Medical Research

Advancing health care knowledge often involves learning from the careful study of health histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements, and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than what is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient's Rights

This law is careful to describe that you have the following rights related to your health information. Be assured that our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately with or without other family members present or through sealed mail communications. We will make all reasonable effort to honor your request.

Inspect and Copy Your Health Information

You have the right to read, review and copy your health information including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend your Health Information

You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process please provide us with your request in writing and describe as completely as possible your reason for the request.

Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested sealed and or delivered to any authority for review.

Documentation of Health Information

You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment, or health care operations. Our documentation procedures will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information, and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes.

You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing any concerns you may have regarding the privacy of your health information.

Thank you very much for taking time to review how we are carefully using your health information. If you have questions, please let us know. If not, we would appreciate your acknowledging by signature that you have received, thoroughly reviewed and understand this policy.

_____ Date _____

SIGNATURE

Houston County Chiropractic Office Policy

While we file all insurance in our office, having insurance is not a guarantee of payment. Some plans do not cover chiropractic care, and in such a case, you will be responsible for payment. Also, some insurance plans have websites in which we can view your coverages. Sometimes the website information is inaccurate. In such a case, you will be responsible for any balance that insurance has not paid.

We take great pride in providing top quality care in our office. Your care plan was designed with your health as the ultimate goal. In order to achieve the best possible results, we recommend you follow your care plan as laid out by our doctors. If you miss an appointment, it will need to be made up within 7 days in order to stay on track with your care plan. We reserve the right to charge a $25 missed appointment fee for anyone who refuses to make up their missed appointments.

I have read and understand the office policy of Houston County Chiropractic.

_____