Chiropractic Case History/Patient Information

Date:______________

PERSONAL INFORMATION

Name:__________________________ Social Security #__________________

Address:____________________________________City:___________________ State:______ Zip:___________

Home Phone: _______________ Cell Phone:_______________ Work Phone: ____________________

E-mail address:________________________________ Birth date: ____________ Age: ____ Sex: ___

Marital: M S W D Occupation:____

Name of person(s) we can discuss your care/account with (name, phone #)?

____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes No Uncertain

# of children ____________

Who may we thank for your referral to our office? __________________________________

HISTORY OF PRESENT CONDITION(S) **Health Goals: ________________________**

Chief Complaint(s):____

Date symptoms appeared or accident happened:_________________________________

Is this due to: Auto Work Other

Have you ever had the same or a similar condition? Yes No

If yes, when and describe:____

Days lost from work:_________________ Date of last physical examination:___________

What does this prevent you from doing or enjoying?

____

Has it become worse recently? Yes No If yes, when & how?

____

____

How frequent is the condition? Constant Daily Intermittent Night Only

How long does it last? All Day Few Hours Minutes

Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing

What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting

Is there anything you have done that relieves the problem? If so, please describe:

____

What have you tried that has **NOT** relieved the problem?

____

Are there any other conditions or symptoms that may be related to your major symptom? Yes No
If yes, describe: ____

____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder
__Circulatory Problems	__Epilepsy	__Alcoholism
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction
__Seizures/Convulsions	__Strokes	__HIV Positive
__A Congenital Disease	__Cancer	__Gall Bladder
__Excessive bleeding	__Ruptures	__Depression
__High/Low Blood Pressure	__Coughing Blood	__Ulcers

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): ____

____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe:____ ***(Over)***

What medications or drugs are you taking?

____

Do you have allergies to any medications? Yes No

If yes, describe:____

Do you have allergies of any kind? Yes No

If yes, describe:____

Please list any other health problems you have, no matter how insignificant they may be:____

SOCIAL HISTORY

Do you drink alcoholic beverages? Yes No If so, how much per week?__________________

Do you use any tobacco products? Yes No If so, packs/dips per day: _________________ __

Do you take vitamin supplements? Yes No If so, please list:___________________________

Do you consume caffeine? Yes No If so, how much per day:__________________________

Do you exercise? Yes No If so, what is the frequency & type of exercise?________________

What are your hobbies?

____

What percentage of time during the day (at home or at work) do you spend:

Lifting_____ Sitting_____ Bending______ Working at a computer______

FAMILY HISTORY

Father: Living Current age: _____ Deceased Cause of death & age: ____________________

Mother: Living Current age: _____ Deceased Cause of death & age:____________________

Do you have any family members who suffer from the same condition you do?

If so, please list:____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis____Cancer____ Mental Illness____Diabetes ____ Asthma____

Heart Disease ____Stroke ____ Kidney Disease____ Lung Disease____Arthritis_____

Liver Disease ____Other ____

INFORMED CONSENT/TREATMENT AUTHORIZATION

I, the undersigned, have been informed by the participating treating Doctor of Chiropractic (D.C.) listed below, that he is a licensed chiropractor who is certified in Acupuncture by the state of Missouri, and having been informed by such Doctor as to the benefits and potential risks of chiropractic treatment, hereby consent to such treatment. I hereby agree to hold Dr. Greene and his affiliates, all associated sanctioned events and/or endorsement levels in Westbrooke Chiropractic & Acupuncture; any and all associated co-sponsorships of any level or participation; free and harmless from any liability, claims, demands, or suits for damages from any injury or complications whatever, which may result from such treatment. This document is binding and the parties hereto intend this Informed Consent Waiver and Authorization to Treat to be binding and inure to the benefit of their respective principals, heirs, executors, administrators, successors, and assigns; includes any and all my successors and/or heirs. I further state that should complication arise from such agreed treatment with treating Doctor of Chiropractic that such individual and myself will be the only parties to engage in any and all recourse should that need arise foregoing any and all others.

Signature: ____

Date: _______________

We do not accept insurance, but we will be happy to provide the necessary documents for you to file on your own. Thank you.

OUR FINANCIAL POLICY

Thank you for choosing us as your health provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment.

All patients must complete our "Patient Information Form" before seeing a doctor.

FULL PAMENT IS DUE AT TIME OF SERVICE. We accept cash, checks, Visa, Mastercard, and Discover. We do offer an extended payment plan with prior credit approval.

Regarding Insurance

We may accept assignment of insurance benefits after your second visit. We do, however require your co-payment as required by our insurance company, to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all the insurance information and an original claim form (if needed). *Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.* In the event that we do accept assignment of benefits we require that you be pre-approved on our extended payment plan or provide a credit card number with authorization to bill that account for the balance. If your insurance company has not paid your account in full in 45* days, the balance of your account will be auto-matically transferred to your credit card or extended payment plan. Please be aware some and perhaps all of the service may be "non-covered" services and not considered reasonable and necessary under Medical insurance.

*Regardless of the insurance company's determination of usual and customary rates or amount of assignment, you are required to pay the full amount charged

Adult Patients

Adult patients are responsible for full payment at time of service

Minor Patients

The adult accompanying a minor and the parents (or guardian) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/Mastercard/Discover or payment by cash or check at time of service has been verified.

UCR (Usual and Customary Rate)

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for paying the bill in full regardless of the insurance company's deter-mination of usual and customary rates.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read and understand and agree to the above financial policy.

Patient or responsible party: X ______________________________ Date: ______________

Co-responsible party: X ______________________________ Date: ______________

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by Michael S. Greene, D.C., F.I.A.M.A., N.M.D. Dipl.Ac., for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Michael S. Greene, D.C., F.I.A.M.A., N.M.D. Dipl.Ac. I understand that diagnosis or treatment of me by Michael S. Greene, D.C., F.I.A.M.A., N.M.D. Dipl.Ac. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Michael S. Greene, D.C., F.I.A.M.A., N.M.D. Dipl.Ac.., is not required to agree to the restrictions that I may request. However, if Michael S. Greene, D.C., F.I.A.M.A., N.M.D. Dipl.Ac., agrees to a restriction that I request, the restriction is binding on Michael S. Greene, D.C., F.I.A.M.A., N.M.D. Dipl.Ac.

I have the right to revoke this consent, in writing, at any time, except to the extent that Michael S. Greene, D.C., F.I.A.M.A., N.M.D. Dipl.Ac., has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected fi7om me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Michael S. Greene, D.C., F.I.A.M.A., N.M.D. Dipl.Ac.., Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the Notice of Privacy Practices for Michael S. Greene, D.C., F.I.A.M.A., N.M.D. Dipl.Ac. The Notice of Privacy Practices for Michael S. Greene, D.C., F.I.A.M.A., N.M.D. Dipl.Ac., is also provided at the front desk. This Notice of Privacy Practices also describes my rights and the duties with respect to my protected health information.

Michael S. Greene, D.C., F.I.A.M.A., N.M.D. Dipl.Ac., reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

X---
Signature of Patient or Personal Representative

X---
Name of Patient or Personal Representative (print)

Witness of Signature

By signing above I acknowledge I have read the above information and I have received the HIPAA Notice of Privacy Practices. I give full disclosure of my information.

MICHAEL S. GREENE, D.C., F.I.A.M.A., N.M.D. DIPL. AC.
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