Chiropractic Registration & History

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 ☐ Separated ☐ Widowed ☐ Divorced

☐ Single ☐ Minor ☐ 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
Name of Insurance Company(ies)

directly to 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's Comp. ☐ Other

Attorney Name (if applicable) _____

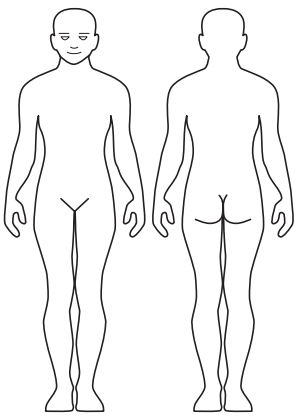
PATIENT CONDITION

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

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	Tonsillitis	☐ 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	☐ Yes ☐ No
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

_____
_____
_____
Pharmacy Name _____
Pharmacy Phone (_____)_____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

Authorization to Receive Information

I hereby grant permission to disclose and/or release all information and records regarding my treatment, diagnostic reports, X-ray reports and consulting reports. Please send copies of my records to:

Chapman Health Group
32749 Radio Road
Leesburg, FL 34788
352-728-6886

Signature: _____ Date: _____

Authorization to Release Information

I hereby authorize the release of any information to my health care companies, Medicare or legal representative with a Request Authorization.

Signature: _____ Date: _____

Authorization to Treat a Minor Child

I hereby request and authorize Chapman Health Group to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor child. As of this date, I have the legal right to select and authorize health care services for the minor child named above.

Signature: _____ Date: _____

Pregnancy Warning and Release

I understand that in the event that I am pregnant and have X-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that the 10 days following onset of a menstrual period are generally considered safe for X-rays. With the full understanding of the above and believing that I am not pregnant or at risk, I wish to have an examination which may include X-rays.

Signature: _____ Date: _____

Chapman Health Group
32749 Radio Road
Leesburg, FL 34788

Tel: 352-728-6886
Fax: 352-728-0823

Acknowledgment Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting us in writing.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name (please print)_____

Patient Signature_____

Date_____

Witness_____

Chapman Health Group
32749 Radio Road
Leesburg, FL 34788

Tel: 352-728-6886
Fax: 352-728-0823

Consent to Use or Disclose Information for Treatment, Payment or Health Care Operations

The Patient herby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by Chapman Health Group, (the "Practice") in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this Consent Form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice may disclose Patient's protected health information and patient medical record information to the following individuals who are either the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient: (Patient must fill out)_____

_____

_____

The Patient agrees that the Practice may disclose the following types of information contained in the Patient's medical records (please initial, do not check, the appropriate categories listed below):

_____ HIV/AIDS Information _____
_____ Mental Health Information _____
_____ Substance Abuse Information _____
_____ Sexually Transmitted Disease Information_____
_____ If Patient is under the age of eighteen (18), Pregnancy Information _____

Patient Name (please print) _____

Patient Signature_____

Date_____

Witness_____

Patient agrees and consents to the Practice releasing information to Patient in the following alternative manners (please **initial**, **do not check**, the appropriate spaces below):

_____ Via e-mail to the Patient's designated e-mail address which is:
_____

_____ Via Regular Mail with any envelopes being marked personal and confidential and addressed to Patient.

_____ Via telephone, if Patient contacts the Practice and provides the appropriate information (including the Patient's name, social security number and unique personal identifier).

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the Consent. If you revoke this consent, CHG will only continue to treat you on an emergency basis, and in that case for 30 days.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I MAY RECEIVE A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATE TERMS.

Date: _____ Time: _____AM/PM

_____
Signature of Patient/Authorized Representative*

_____
Please Print Name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient. Please attach proof of guardianship with a court document:

_____
_____
_____
_____
_____

Blue Cross / Blue Shield Agreement

Dear Patient,

Our contract with Blue Cross/Blue Shield is such that payment of any monies due to this office will be sent directly to you with an explanation of benefits.

While we will file the appropriate insurance forms as a courtesy, it is your obligation to bring or send the reimbursement check(s) and explanation of benefits to this office upon receipt.

Chapman Health Group

Patient Signature: _____

Date: _____

Chapman Health Group
32749 Radio Road
Leesburg, FL 34788

Tel: 352-728-6886
Fax: 352-728-0823

Date: _____ Patient's Name:_____ Medicare#:_____

ADVANCED BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services. We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, **Medicare probably will not pay for:**

Items or Services: Consultation, Examination, X-Rays, Therapies, Massage and Supplies
It has been our experience that Medicare does not cover the above referenced services. However, they require the Examination and X-rays; to support the chiropractic manipulations that you receive. It has been our experience that the chiropractic manipulations will be covered.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make any decision about your options you should:

- **Read this entire notice carefully.**
- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (Estimated Cost: $ _____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ Option 1 – **YES. I want to receive these items or services.** I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you will bill me for items or services and that I will have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.
☐ Option 2 – **NO. I have decided not to receive these items or services.**

_____

Date Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Medicare will keep your health information, which Medicare sees, confidential.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G