binger chiropractic
CLINIC

PERSONAL INFORMATION

Name:_____ Date:_____

I prefer to be called_____

Date of Birth:_____/_____/_____ Age:_____ Sex: ❑ Male ❑ Female Marital Status: S / M / D / W

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:(_____) _____-_____ Mobile Phone:(_____)_____-_____

E-mail:_____

Occupation:_____ Employer:_____

Work Phone:(_____)_____-_____

Spouse's Name:_____ Date of Birth:_____ Age:_____

Emergency Contact:_____ Relation: _____ Phone:(_____) _____-_____

Who Referred You To Us?:_____

CURRENT PRIMARY COMPLAINT:

What is your main symptom?:_____Onset: ❑Sudden ❑Gradual

Rate your discomfort 1-10 (10 is severe)_____Frequency of Discomfort: 0-100%_____

How long have you had this condition?:_____ Type of Pain: ❑aching ❑burning ❑dull ❑numb

❑sharp ❑ shooting ❑throbbing ❑tightness ❑soreness ❑ weakness

Have you had this or similar conditions in the past?:_____

What caused this condition?:_____

What activities are painful to perform?: ❑sitting ❑ standing ❑walking ❑bending ❑sleeping

What position(s), if any, make it feel better?:_____

Over time, is this condition: ❑ Improving ❑ Unchanged ❑ Getting Worse?

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine Other:_____

Describe any treatment you have had for ***this*** condition: ☐Chiropractic ☐Physical Therapy ☐Medical

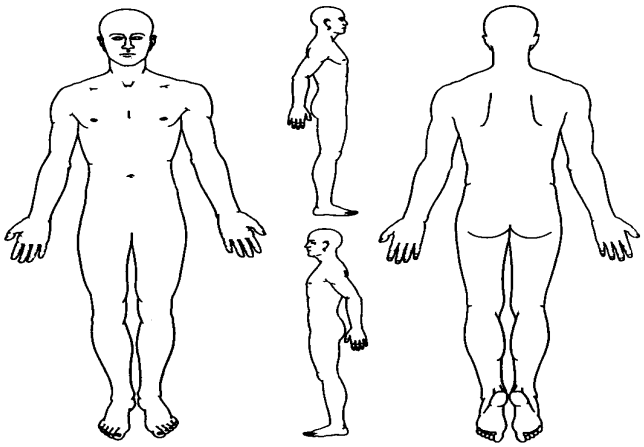
❑Other_____

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name:_____Date:_____

OTHER HEALTH COMPLAINTS

Please list the specific complaints you are experiencing at this time and mark the location on the diagram. Beside each complaint, rate its severity on a scale of 1-10 with 1 being the least discomfort you have experienced and 10 being the most discomfort you have ever experienced.



Additional Complaints:

2) _____ 1 2 3 4 5 6 7 8 9 10

3) _____ 1 2 3 4 5 6 7 8 9 10

4) _____ 1 2 3 4 5 6 7 8 9 10

Do you take medications? ❑ Yes ❑ No List Dosage, Frequency:

_____

_____

Do you have any allergies to medications? ❑ Yes ❑ No_____

Any prior surgeries? ❑ Yes ❑ No Describe with dates:_____

_____

_____

Any prior injuries? ❑ Yes ❑ No Describe with dates:_____

_____

CHIROPRACTIC HISTORY

Previous Chiropractic care? ❑ Yes ❑ No If yes, Doctor's name:_____

Last chiropractic visit: _____

SOCIAL HISTORY

Height:_____ft. _____in. Current Weight:_____ lbs. Recent Blood Pressure (if known): _____

Work Activity: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor ❑ Stressful

Exercise: ❑ None 1 2 3 4 5 6 7 days/week _____minutes Type: _____

Smoking: ❑ Never ❑ Currently ❑ Previously Packs/day:_____, Pack/week:_____ How long?:_____

Alcohol: Beer/week:_____, Liquor/week:_____, Wine/week:_____ How long?:_____

Caffeine: Coffee cups/day:_____ Pop/Soda/day:_____ Energy Drink/day _____

Aspirin: No./day:_____ Ibuprofen:_____/day Tylenol _____/day

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name:_____ **Date:**_____

General

- ❑ Cancer
- ❑ Anxiety
- ❑ Depression
- ❑ Diabetes
- ❑ Thyroid Disease
- ❑ AIDS or HIV
- ❑ High Cholesterol
- ❑ Fatigue
- ❑ Loss of appetite
- ❑ Night Sweats
- ❑ Fever
- ❑ Recent unexplained weight loss
- ❑ Fluoroquinolone antibiotic use
- ❑ Fibromyalgia

Musculoskeletal:

- ❑ Numbness or tingling
- ❑ Difficulty walking
- ❑ Difficulty speaking or swallowing.
- ❑ Neck pain
- ❑ Thoracic pain
- ❑ Low back pain
- ❑ Arm pain
- ❑ Leg pain
- ❑ Fracture
- ❑ Dislocation
- ❑ Arthritis
- ❑ Rheumatoid Arthritis
- ❑ Gout
- ❑ Lupus
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Planter fascitis

Neurological:

- ❑ Equilibrium Disturbance
- ❑ Facial Weakness
- ❑ Headaches
- ❑ Memory loss
- ❑ Stroke
- ❑ Vertigo

ENMT:

- ❑ Nose Drainage
- ❑ Hearing Loss
- ❑ Sleep Apnea
- ❑ Asthma
- ❑ COPD
- ❑ Difficulty Breathing

Cardiovascular

- ❑ Pacemaker
- ❑ Defibrillator
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Heart attack
- ❑ Congestive heart failure
- ❑ TIA
- ❑ Peripheral vascular disease
- ❑ Blood clotting/ bleeding disorder
- ❑ Anemia
- ❑ Swollen Ankles
- ❑ Redness/swelling of a limb
- ❑ Chest pain/heart palpitations

Gastrointestinal

- ❑ Bowel or bladder dysfunction
- ❑ Acid Reflux
- ❑ Appendicitis
- ❑ Bloating
- ❑ Blood in stool
- ❑ Constipation
- ❑ Diarrhea
- ❑ Galls Stones
- ❑ GERD
- ❑ IBS
- ❑ Heartburn
- ❑ Liver Disease
- ❑ Pain or difficulty swallowing
- ❑ Pancreatitis
- ❑ Ulcers
- ❑ Irritible Bowel Syndrome

Genitourinary:

- ❑ Blood in Urine
- ❑ Kidney Disease
- ❑ Kidney Stones

Indicate if you have any immediate family members (father, mother, or siblings) with any of the following:

Rheumatoid Arthritis	Cancer	Diabetes	Heart Problems/Stroke	High Blood Pressure
❑ father	❑ father	❑ father	❑ father	❑ father
❑ mother	❑ mother	❑ mother	❑ mother	❑ mother
❑ sibling	❑ sibling	❑ sibling	❑ sibling	❑ sibling

AGREEMENTS and AUTHORIZATION

INSURANCE INFORMATION

Who is responsible for this account?: _____

Relationship to Patient?: _____

Insurance Co.: _____ Patient ID#: _____ Group #: _____

Is patient covered by additional or secondary insurance? ❑ Yes ❑ No

Subscriber's Name: _____

Relationship to Patient?: _____ Birth Date: _____

Insurance Co.: _____ Patient ID#: _____ Group #: _____

ASSIGNMENT AND RELEASE

I certify that if I, and/or my dependent(s) have insurance coverage, I will assign directly to this office 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. I authorize the doctor or this office to contact me via mail, email and phone in regards to treatment as well as promotional activities. This clinic 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.

I have also received a copy of this office's Financial Policy and Appointment Policy and agree to its terms.

PRINTED Name of Patient, Parent or Guardian: _____

SIGNATURE of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____

(A scanned copy of this document shall serve as the original.)

AGREEMENTS and AUTHORIZATION

Consent To Health Care Services/Release of Health Care Information

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient's behalf), hereby request and consent to Patient health care services from this office. The Patient health care services will be provided by and overseen by licensed, treating physicians. Health care services will also be provided by non-physician health care professionals and assistants employed or otherwise retained by this office.

_____ initial

Payment Guarantee

In consideration of the services provided by this office, Provider to Patient, you agree to; I) guarantee payment of all charges incurred by Patient in connection with such services ("Patient Charges"); II) irrevocably assign and transfer to this office, all right, title and interest to medical reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and III) authorize payment of such benefits directly to this office. You also agree to be fully responsible for the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits.

_____ initial

Notice of Non-Coverage

If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. Your insurance does not pay for all of your healthcare costs, specifically as it relates to treatment in a chiropractic office. Your insurance policy will only cover services that it deems are "Medically Necessary" according to their specific guidelines. When you receive a service or item that your insurance policy does not cover, then you are personally responsible for the non-covered services at the time they were rendered (unless prior arrangements have been made). Specifically, your insurance policy will not allow payment for the following non-covered services and you will have to pay out-of-pocket the normal fee as listed below because they are routinely deemed not-medically necessary according to insurance guidelines: maintenance/wellness chiropractic care, nutritional supplements, therapeutic modalities used for maintenance, massage and any service beyond your benefit plan visit limitations or services that are excluded from the benefit plan.

_____ initial

Patient Right To Restrict Disclosure of Protected Health Information (PHI)

For any service in which you pay for 100% out-of-pocket, you have a right to restrict the disclosure of that healthcare information for that particular service to any health insurance entity. This is according to your HIPAA privacy rights established under the American Recovery and Reinvestment Act (ARRA) of 2009. For services that are non-covered under your insurance plan and that you pay for in-full out-of-pocket, you understand and request that this office does not bill for any of these non-covered services or items on my behalf and that you wish to restrict the disclosure of PHI of these services from your insurance company.

_____ initial

Cancellation Policy

I understand that I will be charged $25 for any missed chiropractic appointment
I understand that I will be charged $40 for failure to cancel any massage appointment within 24 hours of the appointment time.

_____ initial

PRINTED Name of Patient, Parent or Guardian: _____

SIGNATURE of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____

AUTHORIZATION and HIPAA PRIVACY NOTICE

Consent To Release Information

Here at Binger Chiropractic Clinic, we do not sell or release your information to third parties. There will be cases along the course of your care where information will need to be released in certain circumstances. You authorize this office to release to employer groups, government agencies (Medicare, State or Federal government, etc.), insurance companies, or other third-party payers and their agents, and its collection representatives and attorneys, the following "Patient Information": medical history, diagnosis and procedures performed, course of treatment , plan of care, prognosis, supplies and/or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization/payment for Patient's health care services, or billing and collection of amounts due to this office for services rendered. In the case of Patient Information released for purposes of payment of Patient Charges, this authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual health care professional, including treating physician(s), to provide this office or its designee with Patient Information for quality assurance and, or risk management purposes. Finally, in the event that the Patient's employer, or an insurance company representing such employer, requests Patient Information relating to healthcare services provided for worker's compensation injuries, it is understood and agreed that this office is required, under state law, to release copies of such information to such employer or insurance company without the authorization of Patient or Patient's representative. Again, here at this office, we strive to provide you with the best care possible and in order to do that this consent is necessary.

_____ initial

HIPAA Privacy Notice Patient Acknowledgment

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

I hereby state that by signing this Consent I acknowledge and agree as follows:

1) The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request and that a copy of it is always available at the Front Desk.
2) The Practice's Privacy Notice has been provided to me prior to my signing this Consent and a copy of it has been shown to me at the Front Desk. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations.
3) The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.
4) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
5) The Practice's "Notice of Privacy Practices" is also provided upon request. I may also request a copy from this office at any time via US Mail.

This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

_____ initial

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

PRINTED Name of Patient, Parent or Guardian: _____

SIGNATURE of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____

Informed Consent for Chiropractic Care

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I use my hands upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures **please initial**:

_____spinal manipulative therapy
_____ultrasound, hot/cold therapy, or electrical muscle stimulation
_____ _x-ray studies

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.
The availability and nature of other treatment options:

Other treatment options for your condition may include:
- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

PRINTED Name of Patient, Parent or Guardian: _____

SIGNATURE of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____