Adult New Patient Documentation

ChiropracticAlways 26 East Main Street, Brevard, NC 28712 (828)884-5557
drnewton@chiropracticalways.com

Today's Date:_____Can we thank someone for referring you? _____

PERSONAL INFORMATION

Name:_____Age:_____Date of Birth:_____
Address:_____City:_____State/Zip:_____
Home phone:( )_____Business Phone:( )_____Cell Phone:( )_____
SS#:_____E-mail address:_____
Employer:_____Occupation:_____
Marital Status: □ S □ M □ D □ W □ L/W Spouse/Partner's name:_____
Ages of Children:_____
Date you last saw a Chiropractor:_____Dr._____

PATIENT HISTORY

How long has it been since you really felt good?_____
MAJOR COMPLAINT:_____
How long have you had this condition?_____Start date:_____
Have you had this before? ( ) No ( )Yes When?_____
Was the injury related to: ( )Work accident ( )Auto accident? ( ) Other _____
Is your problem getting worse? ( ) Yes ( ) No ( ) Constant ( ) Comes and Goes
What makes the problem worse?_____
Have you lost time form work from this condition? ( ) No ( ) Yes How much lost work?
Is this Problem interfering with your: () sleep ( ) daily routine ( ) other _____
What do you believe to be the cause of your problem? _____

Your expectations from chiropractic care (Check all that apply)
( ) Relief of a symptom or problem ( ) Relief and Prevention of a symptom or problem
( ) Healthier spine and nervous system ( ) Optimal health on all levels

Please mark (0) for past conditions & (X) for present conditions & (F) if condition runs in the family

SECTION I

___Fractured Bones
___Knocked Unconscious
___Emotional Upsets
___Diabetes
___Convulsions/Epilepsy
___Bruise Easily
___Auto Accidents
___a. 0-1 years ago
___b. 1-5 years ago
___c. more than 5 years
___Skin Problems
___Cancer
___Other Accidents/Falls
___Back Curvature
___Arthritis
___Swollen or Painful Joints
___Itching
___Frequent Colds/Flu

SECTION II

___Nervousness
___Anemia
___Eyes sensitive to light
___Light headed upon Arising
___Eating Disorders
___Tension
___Excess Sweating
___Allergies
___Under Stress
___Irritable
___Tremors
___Sinus Problems
___Crave sweets/Salt

SECTION III

___Trouble Sleeping
___Learning Disability
___Dyslexia
___Trouble Concentrating
___Mistake Sidedness (L to R)
___Mood Changes
___Loss of Memory
___Stutter
___Lose Temper Easily

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SECTION IV

___Headache
___Jaw Pain, click (TMJ),(R,L)
___Tired Head & Shoulders
___Shoulder Pain
___Ringing in Ears (R,L)
___Upper-back Pain, stiffness (R,L)
___Numbness, tingling or pain in buttocks, thighs, legs, feet or toes
___Stiff Neck/Neck Pain (R,L)
___Head seems too heavy
___Difficulty with standing, sitting, walking, bending, twisting, housework
___Hearing Loss
___Mid-back pain, stiffness (R,L)
___Hip Pain (R,L)
___Pain with cough, sneeze or strain at stools
___Numbness, tingling, pain in arms, hands, fingers (R,L)
___Dizziness
___Fainting
___Lower-back pain (R,L)
___Foot Trouble (R,L)

SECTION V

___Chest Pain
___Wheezing
___High/Low Blood Pressure
___Gall Bladder Problems
___Asthma
___Heart Problems
___Varicose Veins
___Lung Problems
___Stroke
___Liver Problems

Section VI

___Digestive Problems
___Heartburn
___Hemorrhoids
___Excessive Gas
___Diarrhea/Constipation
___Prostate Problems
___Belching, bloated after meal
___Colon Problems
___Impotence

SECTION VII

___Kidney Problems
___Painful Urination
___Breast lumps, soreness, discharge
___Ear Infections
___AIDS/ARC
___Kidney Stones
___Discharge
___Pregnant (now)
___Hepatitis
_____
___Frequent Urination
___Menstrual Issues/PMS
___Bedwetting
___Venereal Disease
_____

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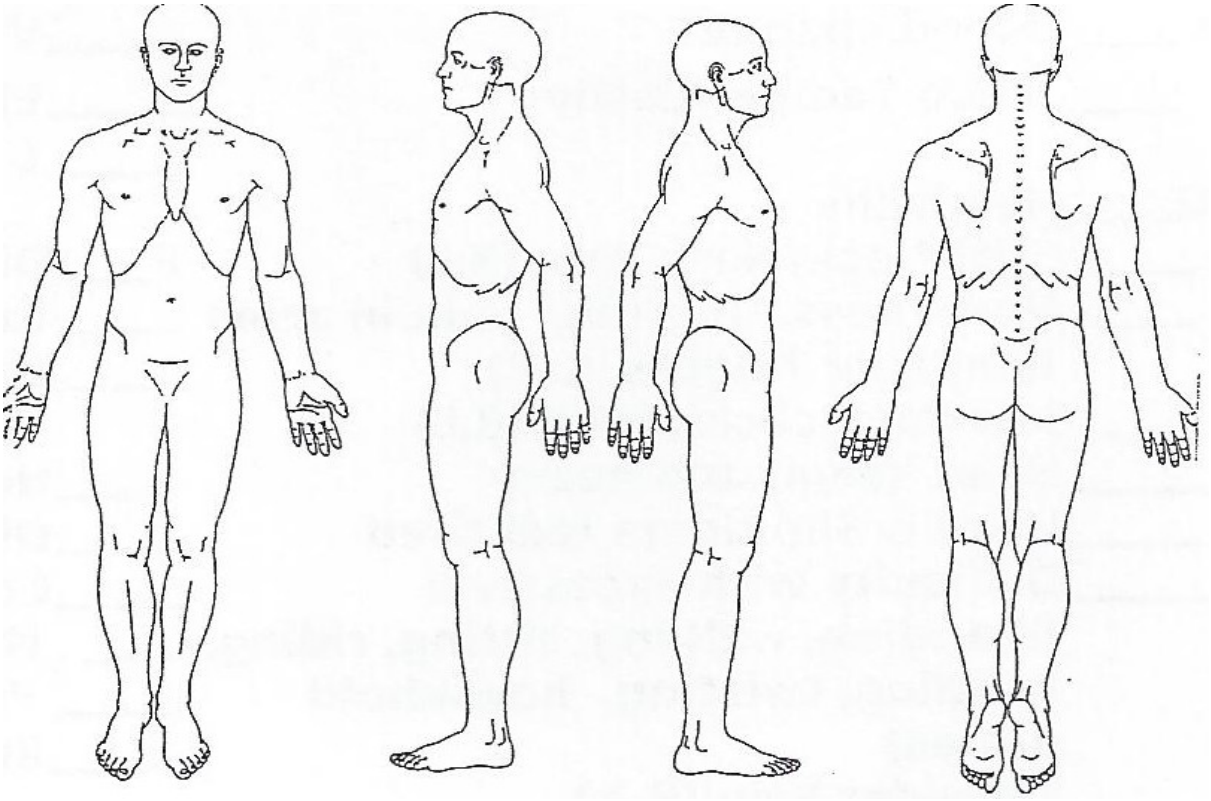

What surgeries have you had & WHEN? Please list as S1, S2, S3 on the diagram.
What broken bones have you had & WHEN? List as Fl, F2, F3 on the diagram.
What injuries from accidents have you had when? List as A1, A2, A3 on the diagram.

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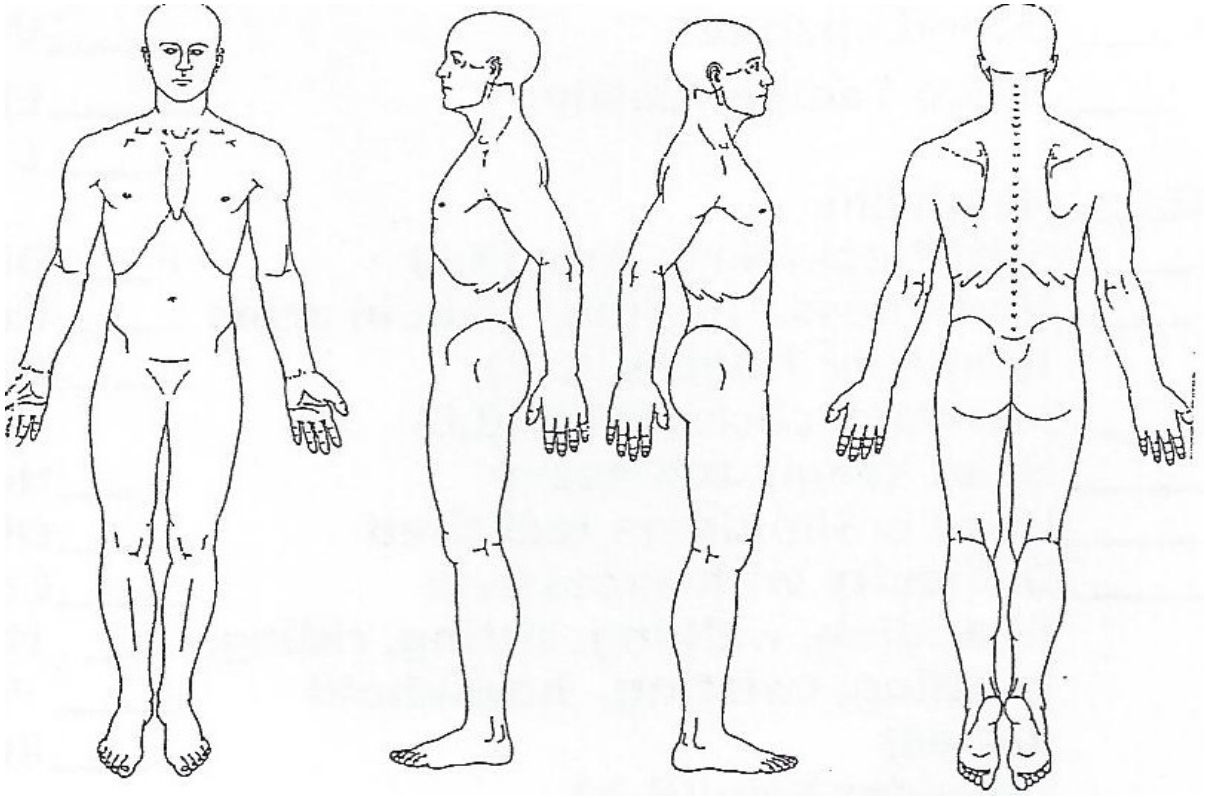

Locate the tension felt in your body by placing Tl, T2, T3 on the diagram below.
Locate the areas of restriction by placing R1, R2, R3 on the diagram which follows.
Locate the areas of pain in your body using Pl, P2. P3 (Rate the pain on a scale of 1-10, 1=low, 10= high) on the diagram below. Indicate if the pain is dull, sharp, constant, on and off, when standing, only when sitting, etc.

The information I have provided on this case history form is true and accurate to the best of my knowledge.

Signature Date:_____

Patient Name_____

Patient Address:_____

Patient Signature:_____

Guardian/Spouse/Parent Name_____Signature:_____

Information Taken by:_____

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PAYMENTS and INSURANCE VERIFICATION

Insurance is a contract between the insured, the patient, and the insurance company. The following information will help you to understand how insurance can be utilized in our office and the details regarding your participation in the process.

Please have the following information when calling your insurance company:

1. Insurance company's phone number (on the back of your card):_____
2. Policy holders name (if different from patient):_____

Please obtain and verify the following information. They cannot process your claim without this information.

1. Ask for the name of the person giving you this information:
2. Ask if you have chiropractic coverage for out of network providers. If yes, please continue to verify type and amount of coverage.
3. What is the yearly deductible: _____ Per Person: _____Per Family:_____
4. How much of the deductible has been met this year?_____
5. What is the co-pay:_____
6. Is there a limit to the number of visits or a $ amount? _____ If yes, how many visits are allowed and/or what is the $ limit?: _____
7. Are services limited by Medical Necessity? _____
8. Does your plan cover Wellness or Maintenance Care? _____
9. What is the effective date of the policy? _____
10. Policy holder's employer: _____ ID# _____Group # (if applicable): _____

a. **Name and address of the insurance office where the claims are sent:**

_____

_____

_____

Thank you for obtaining and verifying this information with your insurance company. We expect they will reimburse you or your account as noted above.

SUBMITTING BILLS TO YOUR INSURANCE COMPANY

If you determine that your insurance plan will reimburse you for chiropractic care in our office, we will provide you with itemized monthly statements for you to submit. Please indicate below the type of statement you may need.

☐ Flex Plan or Health Savings Account Statement

☐ Insurance Statement

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INSURANCE PROCEDURES:

Insurance companies, such as HMO's, PPO's and others, create their own guidelines and are not required to cover chiropractic services. If chiropractic services are covered, the amount and type of reimbursement varies according to the policy that has been purchased by you or your employer. (See reverse for details)

If you have determined that your insurance will cover your care in our office, we will supply you with all of the paperwork necessary for you to get reimbursed quickly. We will give you a statement at the end of your first week and then once a month after that. When you send in your statements, your insurance company will reimburse you directly. They are responsible to you, as the subscriber, not to us, the provider.

AUTO ACCIDENTS AND WORK-RELATED INJURIES:

If your insurance company requires direct billing from us, we will supply the necessary information for them to remit payment to our office on your behalf. Please understand that you are responsible to pay for all services until we receive approval and/or payment from the insurance carrier. Once payment is verified you will be reimbursed accordingly. You are still responsible for deductibles, co-payments, and any other balances not reimbursed by the insurer.

NOTE: You must verify the type and amount of coverage before we can submit claims on your behalf. Until we receive this information and verification and/or payment from the insurance company, your account will be on a cash basis.

I have read, understand and agree to complete all forms necessary to allow ChiropracticAlways to assist me with insurance reimbursement. I understand that I am personally responsible for all services received should my insurance fail to remit payment. I agree to pay for all services I receive here on the date they are provided.

Date:_____

Patient Name_____

Patient Address:_____

Patient Signature:_____

Guardian/Spouse/Parent Name_____Signature:_____

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CONSENT FORM

- A copy of ChiropracticAlways' "Notice of Privacy Practices for Protected Health Information (HIPAA)" brochure is available for my review both in the office and on www.chiropracticalways.com website.
- I consent to receive communication from ChiropracticAlways in connection with my care via email, postal mail, text and telephone messaging. If I should withdraw my consent, I will notify the office in writing.
- I consent to my photo or image being used in photograph or video in public media including social media, website, promotional materials. If I should withdraw my consent, I will notify the office in writing.
- It has been explained verbally and in writing that Chiropractic can sometimes have side effects or risk of ataxia, bruising, thermal injury, dislocation/subluxation, dizziness, "drop attacks", fracture, mobility disruption, paralysis, quadriplegia, spinal injury, stroke/disruption of blood flow to the brain, visual disturbances, pain, tinnitus, hallucination or death. While none of these complications have ever occurred under my care, should this happen in your case, for your protection, you would be referred immediately to another physician or appropriate health care provider for surgery or other "standards of care" treatment.
- On rare occasions side effects of massage can include bruising, inflammation, swelling and pain.
- I acknowledge that the risks of Chiropractic treatment have been explained to me verbally and in writing, I assume full responsibility for these risks.
- Should I choose detoxification as a treatment with Dr. Newton, I recognize that as my body releases poisons, there may be associated memory which comes to the surface (somatic-visceral) and I agree to obtain professional council upon the recommendation of Dr. Newton.
- I understand that detoxification can sometimes have side effects or risk of nausea, vomiting, diarrhea, memory recall and fainting.
- I fully understand the above Consent Form Information. I fully understand the risks and limitations of Chiropractic Care, Massage and Detoxification. I understand and fully consent to treatment with Dr. Newton for Chiropractic, Massage and Detoxification when it has been determined the care is needed. No guarantee of assurance of results has been made. I agree and intend this consent form to cover the procedures recommended in my case including the use of Chiropractic Care, Evaluation, Diagnosis, Adjustments, massage, Detoxification Methods, Manipulations, and treatment for any future conditions for which I seek treatment.

Date:_____

Patient Name_____

Patient Address:_____

Patient Signature:_____

Guardian/Spouse/Parent Name_____Signature:_____

Witness: _____

Welcome to ChiropracticAlways!