PERSONAL HISTORY

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

Mailing Address

City\_­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­ State\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_ Sex: 􀂅 Male 􀂅 Female Marital Status: 􀂅 M 􀂅 S 􀂅 D 􀂅 W 􀂅 SEP

Social Security \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-mail Address

Home Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone #

Race (Circle one): American Indian / Asian / African American / White (Caucasian) / Pacific Islander / Other / Decline to Answer

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:

Address

City\_­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­ State\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip

Work Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact Phone #

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen a chiropractor before? 􀂅 Yes 􀂅 No

For office use only

Height: \_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_ Blood Pressure\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Pulse: \_\_\_\_\_\_\_\_\_\_

INJURY STATUS

**Reason for today’s visit:** 􀂅 Emergency 􀂅 New Injury 􀂅 Old Injury 􀂅 Chronic

**Did your injury occur during:** 􀂅 Sports/ Play 􀂅 Accident 􀂅 Routine/ Household activity 􀂅 Other

**When did your condition/ accident occur?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Where did your injury occur?**

**Please explain what happened:**

**How often do you experience symptoms?** (Circle one) Constantly Frequently Occasionally Intermittently

**Describe your symptoms?** (circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

**Is your condition getting worse?** 􀂅 Yes 􀂅 No 􀂅 Constant 􀂅 Comes and goes

On a scale of one to ten how intense are your symptoms? Not intense 🄋 ➀ ➁ ➂ ➃ ➄ ➅ ➆ ➇ ➈ ➉ Unbearable

**My condition is aggravated by:**

􀂅 Standing too long 􀂅 Sitting too long 􀂅 Driving 􀂅 Sneezing 􀂅 Coughing

􀂅 Pulling 􀂅 Laying on my back 􀂅 Laying on my stomach 􀂅 Bending 􀂅 Bowel movement

􀂅 Pushing 􀂅 Twisting 􀂅 Stooping 􀂅 Vacuuming 􀂅 Lifting over \_\_\_\_\_\_\_\_\_\_lbs.

Is your condition interfering with your: 􀂅 Work 􀂅 Sleep 􀂅 Daily Routine? If so, how:

CURRENT HEALTH CONDITION(S)

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**Using the adjacent body charts, please *circle* all affected areas.**

**What are your current health condition(s)?**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you been treated by another physician for this/these condition(s)?**

􀂅 Yes 􀂅 No If so, please list other Doctors:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LEFT BACK FRONT RIGHT**

**Medication Currently Taking:**

|  |  |
| --- | --- |
| Medication Name | Dosage & Frequency |
|  |  |
|  |  |
|  |  |

**Medication Allergies:**

|  |  |  |
| --- | --- | --- |
| Medication Name | Reaction | Onset Date |
|  |  |  |
|  |  |  |

List any surgeries or hospitalizations you have had complete with the month and year for each:

Do you have or have you had any diseases, medical conditions or procedures?

List any past serious accidents with dates:

Family Health History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

Previous X-rays taken? 􀂅 Yes 􀂅 No Areas:

Do you exercise? 􀂅 Yes 􀂅 No Hours per week\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What activity(s)?

Are you dieting? 􀂅 Yes 􀂅 No Since: \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcoholic beverages? 􀂅 Yes 􀂅 No \_\_\_\_\_\_\_\_\_\_\_\_\_\_drinks per day

Do you use tobacco? 􀂅 Yes 􀂅 No \_\_\_\_\_\_\_\_\_\_packs per day. How many years have you been using tobacco?

Do you wear? 􀂅 Heel lifts 􀂅 Arch supports 􀂅 Prescription Orthotics 􀂅 No If so who recommended them?

*For women:*

Are you pregnant or nursing? 􀂅 Yes 􀂅 No If pregnant, how many weeks?

Date of last menstrual period:

**HIPPA PRIVACY**

Prater Mountain Health Clinic

Darnell Simpson D.C.

Devin Simpson D.C.

Eric A. Anderson P.A.

118 S. Main St. Suite B

Thayne, WY 83127

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Phone: 307-883-7246

Fax: 307-883-7247

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third party payers.
* Conduct normal healthcare operation such as quality assessment and physical certifications.

I have received, read and understand the “Notice and Privacy Practice” which containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

I choose to decline receipt of my clinical summary after every visit. At any time I can request they be emailed to me.

***Financial Policy***

**Payment:**

If you have insurance and wish to bill your own insurance, we will supply you with a super bill to do so. (You will pay TOS prices) If you would like Prater Mountain Health Clinic to bill your insurance, we will be happy to do so and you will pay insurance prices. **We ask that you pay your co-pay, co-insurance and/or deductible at time of service. If payment is denied by your insurance company you will be responsible for the amount not covered and a statement will be mailed to you. Your account may be assessed interest and/or late fees after 30 days. I/We further agree to pay a finance charge of 18% monthly interest rate of the unpaid balances, or a minimum of $1.50 per month.**

**Collections**: All accounts over 90 days past due or not in good standing will be turned over to our collection agency. Monthly payments must be made to keep your account current. You will be responsible for any legal fees if legal action is taken.

**Missed Appointments**

We require at least 24 hours notice if you need to change or cancel your appointment. If you fail to keep your appointment, **or do not provide us with 24 hours notice**, you will be charged the standard cost of the appointment fee. Broken appointment fees must be paid prior to rescheduling your next appointment.

I have read the above statement and understand this office policy.

**Record Release and Assignment of Insurance Benefits**

The undersigned hereby authorizes the Release of any information relating to claims for benefits submitted. I further agree and acknowledge that I authorize my physician to submit claims for benefits, for services rendered, without obtaining my signature on each claim.

I hereby authorize my Insurance company to pay and hereby assign directly to Dr. Darnell Simpson and/or Dr. Devin Simpson and/or Eric Anderson P.A. all owed benefits. I understand I am financially responsible for all charges incurred.

Patient Signature Date

Parent or Guardian Date

**Your consent and authorization for treatment**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

**I am aware that this consent covers the care and treatment that I will receive at Prater Mountain Health Clinic under the care of any of its health care professionals.**

I consent to treatment and care for myself, or as a legal guardian of the patient in question.

I am aware that my care and treatment might include any of the following services.

* Emergency treatment services
* Laboratory procedures
* Imaging services
* Medical or minor surgery treatments or procedures
* Injections
* Urgent care treatment and procedures
* Chiropractic treatment and procedures
* Massage treatment and muscle manipulation

I am aware that medicine/chiropractic is not exact sciences.

I agree that no one has made guarantees to me about the results of the services I will receive. This includes the results of any diagnosis, treatment, surgery, test, adjustment or exam that has been or will be done.

I know that I can refuse to consent to any procedure or treatment.

**Exemptions**

As a part of the analysis, examination, and treatment, you are consenting to all chiropractic and medical treatment and procedures. If there is anything for which you do not consent to please list below. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The material risks inherent in health care.**

As with any healthcare procedure, there are certain complications which may arise during any health care treatment that is intended to help or heal. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, costovertebral strains and separations, infections and burns. Our health car providers 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 our attention, it is your responsibility to inform us.

**CONSENT TO TREATMENT**

I hereby request and authorize Dr. Darnell Simpson, Dr. Devin Simpson and Eric A. Anderson PA to perform diagnostic test and render chiropractic adjustment, medical care and other treatments to myself or my minor son/daughter.

As of this date, I have the legal right to select and authorize health care services for the minor child named above, (if applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

**I have read or have had read to me the above consent explanation concerning treatment and care. I have discussed it with *Dr. Darnell Simpson, Dr. Devin Simpson or Eric A. Anderson PA* 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.**

**This consent may be revoked in writing by me at any time.**

Revoking this consent will not change actions that have been taken while the consent was in place.

**Patient Name (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IF PATIENT IS UNABLE TO CONSENT OR IS A MINOR, PLEASE COMPLETE**

Patient named above is a minor, \_\_\_\_\_\_\_years of age.

Patient named above is unable to sign because:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Mother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Father\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Legal Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attending Provider Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature