DAWSON
SPINE & SPORT
FEEL BETTER. MOVE BETTER. LIVE BETTER.

Name: _____ **Date:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Numbers **Cell:** _____ **Home:** _____

E-mail address: _____

Social Security Number (to verify insurance benefits): _____

I consent to appointment reminders via email and/or text: **YES** ☐ **NO** ☐

Date of birth: _____ **Age:** _____ **Gender:** **Male** ☐ **Female** ☐

Marital Status: Child Single Married Divorced Widowed

Preferred Language: _____

Race (Circle One): American Indian or Alaska Native Black or African American
White or Caucasian Native Hawaiian/Pacific Islander
Asian I Decline to answer

Smoking Status (Circle One): Current Everyday Smoker Current someday smoker
Former smoker Never Smoked

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

Employment Status (Circle One) : Full Time Part Time Student
Homemaker Retired Unemployed
Disabled (since _____)

Occupation: _____
Employer: _____

Emergency Contact: _____
Relationship: _____ **Phone Number:** _____

Tell us how you heard about us

My employer: _____ My friend: _____
Social Media: _____ Event: _____
Newspaper: _____ Other: _____

Health Information

Are your complaints due to an auto accident or workplace injury? YES ☐ NO ☐
Purpose of this appointment: _____
Other Doctors seen for this condition: _____
When did this condition begin: _____
Please list all accidents or hospitalizations with the last year: _____

_____

Chiropractor: YES ☐ NO ☐ Doctor Name & Date of last visit: _____

Check any of the following illnesses or conditions that apply to YOU:

Allergies	Cancer	Irritable Bowel Syndrome	Other_____
Arthritis	Diabetes	Lung Disease	_____
Asthma	Heart Disease	Neck Surgery	_____
Back Surgery	High Blood Pressure	Previously Broken Bones	_____
		_____	

Family Health History
If any, specify who the follow conditions apply to (Mother, Father, Sibling, or Children)

Allergies	Cancer	High Blood Pressure	Other_____
Arthritis	Diabetes	Irritable Bowel Syndrome	_____
Asthma	Heart Disease	Lung Disease	_____

Medications

Are you currently taking any medications? YES ☐ NO ☐ (Include any over the counter meds)

Medication Name		Dosage and Frequency (i.e. 5mg once a day, etc)

Do you have any medication allergies? YES ☐ NO ☐ (If yes please document below)

Medication Name	Reaction	Onset Date	Additional Comments

Print Name: _____

Patient/Parent Signature : _____ **Date :** _____

Financial Responsibility

Please read the following statements and check off all that apply to you and your insurance type and/or your financial responsibilities and then sign at the bottom of the page.

☐ **Self-Paying Patient / Cash**

Any and all services performed in our office will be explained to you prior to the services being rendered. I understand, by signing this form, all charges I have been notified of and agreed upon will be my personal responsibility. I also understand that my balance shall not exceed $300.

☐ **Patients With Insurance**

You are responsible for deductibles, copays, non-covered services, coinsurance and items considered "not medically necessary" by your insurance company. Please pay copay amounts as services are rendered. The remaining balance should be taken care of within one month of notice from your insurance company. Balances dues shall not exceed $300.

If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit notify the front desk staff to make other arrangements.

I authorize, by signing below, the release of medical information necessary to process claims on my behalf. I also request payment of government benefits either to myself or the party who accepts assignment in the service described on the Health Insurance 1500 claims form. I understand and agree that health and accident policies are an agreement between an insurance carrier and me. We accept assignments as a courtesy to you. We are not a mediator between you and your insurance company. We will not enter into a dispute with your insurance company. Furthermore, I understand that Dawson Spine & Sport will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Dawson Spine & Sport will be credited to my account upon receipt. However, I clearly understand that all services rendered to me are charged to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or professional services rendered to me will be immediately due and payable. I am also aware that at any time I have a question regarding my insurance coverage or payment; I will ask to speak to the finance department.

Patients with Medicare: Our office will submit your Medicare charges to Medicare and your secondary Insurance. ***You are responsible for deductibles, copays and any non-covered services***.

Please use your insurance cards to fill out the following fields that apply

Primary Insurance Information:

Insurance Name: _____ ID #: _____
Name of Insured: _____ Group #:_____
Relationship to patient: _____ Insurance phone #: _____
Insured Social Security #: _____ Insured Date of Birth: _____
Insured Address: _____

Secondary Insurance Information:

Insurance Name: _____ ID #: _____
Name of Insured: _____ Group #:_____
Relationship to patient: _____ Insurance phone #: _____
Insured Social Security #: _____ Insured Date of Birth: _____
Insured Address: _____

Insurance Responsibility Acknowledgement

Please sign and date below, no matter if you do or do not have insurance.

Print Name: _____

Patient/Parent Signature: _____ **Date:** _____

HIPAA PRIVACY

AUTHORIZATION FOR USE AND DISCLOURE OF PERSONAL HEALTH INFORMATION
AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing. Dawson Spine & Sport will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested us of disclosure, YOU MAY REFUSE TO SIGN THIS AUTHROIZATION.

By signing this authorization, you acknowledge and agree that some of our treatments are performed at Dawson Spine & Sport in an open setting where incidental disclosures may occur. You also agree that Dawson Spine & Sport may use or disclose your personal health information for referral to other health care providers with your permission, any billing or collection activities or proceedings, leaving messages on answering machines or making phone calls to you regarding scheduling of appointments, your health benefit coverage and related discussion of your care, or phone or mail notifications of any internal office promotions.

Please identify the family members, friends, or other persons who are or will be involved in your care of payment for health care and with whom you authorize us to share your protected health information:

Name	**Relationship to you**	**List information to be shared**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Dawson Spine & Sport's NOTICE OF PRIVACY PRACTICES containing a description of your rights, and permitted uses and disclosures, under HIPAA. While Dawson Spine & Sport has reserved the right to change the terms of its NOTICE OF PRIVACY PRACTICES, copies of the NOTICES, as amended, are available from Dawson Spine & Sport, at our office or by sending a written request with return address to Dawson Spine & Sport, 410 West Jefferson Street, LaGrange, KY 40031, Attn: Office Manager. You have the right to revoke this authorization, in writing, at any time, except to the extent that Dawson Spine & Sport, has taken action in reliance on it. A revocation is effective upon receipt by Dawson Spine & Sport, of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Dawson Spine & Sport, or (d) two (2) years from the date this authorization was executed. By signing this authorization, you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

ACKNOWLEDGED AND AGREED TO BY:

Patient Name: _____ Date: _____

Patient Signature: _____

OR

Print Name of Parent/ Guardian of Minor: _____

Parent/Guardian Signature: _____

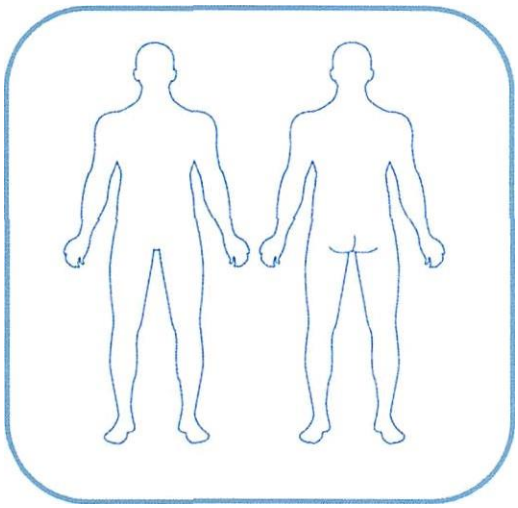
Relationship: _____

Current Personal Health

Please check any of the following symptoms you have or have had in the past 6 months.

Neck Pain	Hand/Wrist Pain	Ear Aches/Infections	Migraines
Shoulder Pain	Knee Pain	Chest Pain	Dizziness/Light Headedness
Upper/Mid Back Pain	Foot Pain	Heart Problems	Heartburn/Indigestion
Low Back Pain	Ankle/Leg Swelling	Constipation	Vomiting/Diarrhea
Hip Pain	Leg Pain	Bladder Trouble	Loss of Sleep
Buttock Pain	Joint Pain/Stiffness	Allergies	Shortness of Breath
Jaw Pain	Cold/Tingling Extremities	High/Low Blood Pressure	Walking Trouble
Arm Pain	Numbness in Extremities	Headaches	Excessive Weight Gain/Loss

Mark an area of pain or discomfort



Consent To Treatment:

As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerve or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications. The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from taking a single aspirin tablet. The risk of cerebrovascular **injury or** stroke has been estimated at one in one million, to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Patient Name: _____

Patient Signature: _____ **Date**: _____

Consent To Treatment of Child/Minor

If child is not your biological child, we must have guardianship documentation before treatment

I hereby authorize the doctor in the off and whomever they may designate as assistants to administer chiropractic care as deemed necessary to my son/daughter. Parent or Legal Guardian must be present during first visit, first treatment, and to make financial agreements. Legal documentation is required for those who may have the authority to consent to the treatment of a child/minor, such as a legal guardian or family member.

_____	_____	_____	_____
Patient's Name	**Print Parent/Guardian Name**	**Parent/Guardian Signature**	**Date**