

Derleth Chiropractic

Patient Registration

Today's Date _____

Last Name _____ First Name _____ Initial _____

Street _____ City _____ State _____ Zip _____

Home Phone #(____) _____ Work Phone #(____) _____

Cell Phone #(____) _____ E-Mail _____

Date of Birth ____/____/____ Sex _____ SS# _____ - _____ - _____ Marital Status _____

Employer _____ Occupation _____

Street _____ City _____ State _____ Zip _____

How did you hear about our practice? _____

Is your current condition related to Employment? NO YES

Is your condition related to an Auto Accident? NO YES

Other Accidents? NO YES Please describe _____

When did your present symptoms appear? _____

Have you ever had any complaints in the involved area before? NO YES

If yes, please explain: _____

INSURANCE INFORMATION

To ensure all billing is submitted properly, please provide us with the following information. The front office will also need to make a copy of your insurance card for our records.

Insurance Company _____ Phone #(____) _____

Street _____ City _____ State _____ Zip _____

Name of Insured _____ SS# _____ - _____ - _____ Date of Birth _____

Policy # _____ Group # _____ Contract # _____

Employer of the Insured _____ Relation (patient/insured) _____

Street _____ City _____ State _____ Zip _____

In case of emergency, who should be notified? _____

Phone #(____) _____ Relationship to patient _____

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Chiropractic health care stresses the treatment of the WHOLE person, not just your back and neck.
To help us understand your health history, we ask that you fill out this questionnaire.

Please check any boxes that apply to you NOW...

<u>Symptoms</u>	<u>Symptoms</u>
<input type="checkbox"/> Headaches	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Fainting
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Loss of Smell
<input type="checkbox"/> Trouble sleeping	<input type="checkbox"/> Loss of Taste
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Tension	<input type="checkbox"/> Cold Hands
<input type="checkbox"/> Irritability	<input type="checkbox"/> Cold Feet
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Muscle Spasms
<input type="checkbox"/> Shoulder/Arm/Neck Pain	<input type="checkbox"/> Frequent Colds
<input type="checkbox"/> Pins & Needles in Arms	<input type="checkbox"/> Upset Stomach
<input type="checkbox"/> Pins & Needle in Legs	<input type="checkbox"/> Constipation
<input type="checkbox"/> Numbness in Fingers	<input type="checkbox"/> Cold Sweats
<input type="checkbox"/> Numbness in Toes	<input type="checkbox"/> Fever
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Allergies	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Weakness in the Arms	<input type="checkbox"/> Leg Cramps
<input type="checkbox"/> Weakness in the Legs	<input type="checkbox"/> Colitis
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Gall Bladder
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Indigestion
<input type="checkbox"/> Depression	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Shoulder Pain
<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Knee Pain
<input type="checkbox"/> Ringing in the Ears	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Face Flushing	<input type="checkbox"/> Menstrual Problems
<input type="checkbox"/> Buzzing in the Ears	<input type="checkbox"/> Positive for HIV or AIDS

Have you ever had chiropractic care before? Yes No

If so, when and with whom? _____

Do you have any Allergies? Yes No If so, to what are you allergic? _____

Have you ever broken any bones? Yes No If so, which ones and when? _____

Patient's Name: _____

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Have you dislocated any Joints? Yes No

If so, which joints? _____

Please list any operations you have had:

1. Year _____ Operation _____
2. Year _____ Operation _____
3. Year _____ Operation _____
4. Year _____ Operation _____

Have you been treated by a physician for any other health conditions in the last year?

Yes No If so, for what condition? _____

Have you lost or gained weight in the last year? Yes No

Are you currently taking any medications? Yes No

If so, what medication? _____
(Please list dosage) _____

Do you take vitamins or herbs? Yes No

If so, what type and how much? _____

Who is your Primary Care Physician? _____

Where are they located? _____ Phone: _____

When was your last:

	<u>0-6 Months</u>	<u>6-12 Months</u>	<u>Over 12 Months</u>	<u>Never</u>
Physical Exam:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine Test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
X-rays:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any of the following habits?

Alcohol Yes No How Much? _____
Coffee/Tea Yes No How Much? _____
Tobacco Yes No How Much? _____
Exercise Yes No How Much? _____

Is there anything else about your health history that you think we should know? _____

Patient's Name: _____

Current Pain Diagram

Name: _____ Date: _____

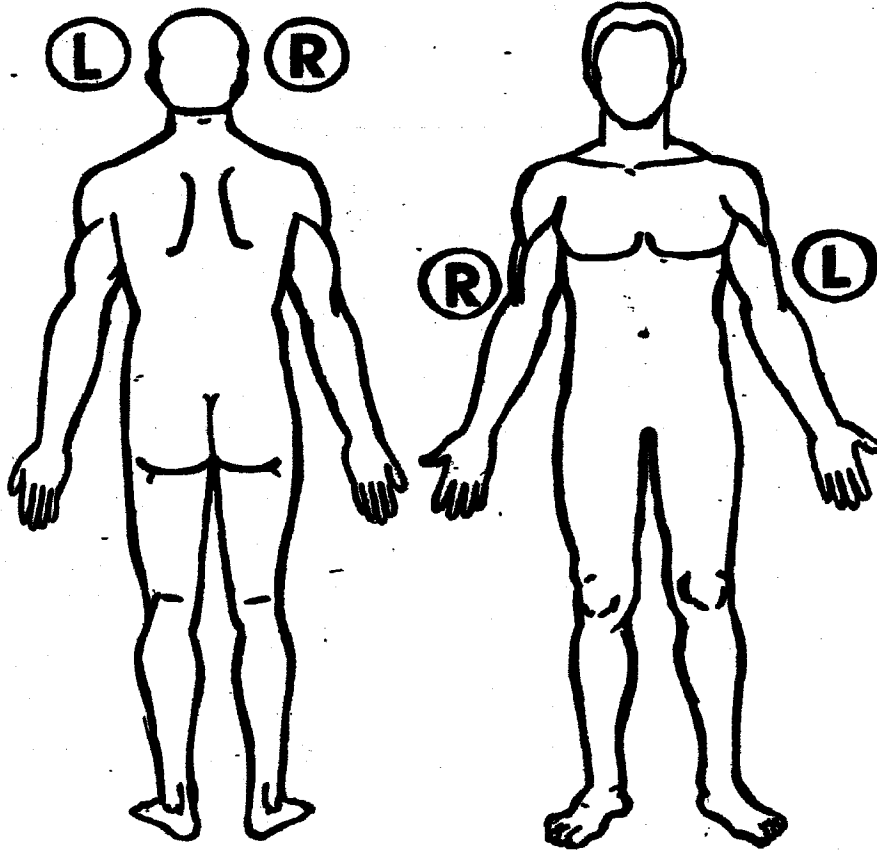
Mark all the areas of your body where you feel pain **NOW**.
Use the symbols below to describe the type of pain in the area of pain.

ACHE #####
BURNING xxxxx

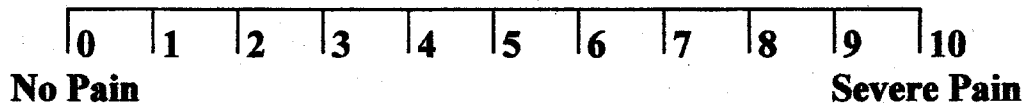
NUMBNESS ===
STABBING ///

PINS & NEEDLES oooo
OTHER ^^^^ (please describe)

Draw at the location of your pain **TODAY**



Rate Your Pain For **TODAY**



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Financial Policy

SCHEDULING

- All appointments during regular hours must be scheduled so as to reduce waiting time for you and others.
- You are free to stop in at any time, but you will have to wait until all scheduled appointments are seen. You will be fit in as soon as possible
- Cancellations require 24 hour notice. **THERE IS A \$20.00 FEE OTHERWISE.**

PAYMENT

- Payment is expected in full at the time services are rendered. This includes all co-payments.
- For your convenience we accept Cash, Checks, MasterCard and Visa.
- Payments on your deductible will be made by paying our per visit charge until it is met.
- Should you discontinue care for any reason other than discharge by the doctor, any outstanding balances will become immediately due and payable in full by you.

INSURANCE

- Our office will verify your insurance coverage in effort to help you determine exactly what chiropractic coverage is available under your policy.
- It is your responsibility to provide us with all the appropriate insurance forms, addresses, and information so that proper filing can be done.
- We are not obligated to accept your insurance payment on assignment although for your convenience, we may based on our experience with your insurance carrier.
- You are always responsible for the portion of your bill that the insurance may not cover and for your annual deductible.
- Remember that your insurance coverage is a contract between you, your employer and the insurance company. We do not bill any secondary insurance carriers.

FEES

- Our fees generally fall between what is considered reasonable and customary for this area.
- Many insurers pay a percentage of the reasonable and customary rate, called the Co-Pay.

LASTLY

- You are responsible for all charges incurred as a patient of this office.
- We will do all we can with your insurance claims, but ultimately, you are responsible for payment.
- Past due statements for unpaid balances will be mailed. Statements unpaid for more than 30 days may be subject to an interest charge. In the effort to avoid expensive collection agency fees we hold the right to automatically bill any unpaid and outstanding balances, including interest payments to any credit card account on file in our office.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regards to your health or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

I, the undersigned, have read and agree to the guidelines of this financial/insurance policy. I also fully acknowledge that I have insurance coverage with _____ Insurance Company and assign directly to **Derleth Chiropractic, PLLC** all medical 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 hereby, authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Patient's
Signature: _____

Date: _____

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HIPPA - PATIENT CONSENT **FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

(Name) _____ hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. 1 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. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. 2 The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent. 3

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice. In accordance with applicable law. 5

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice:
a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone. 6

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations. 7

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. 8 However, the Practice is not required to agree to any restrictions that I have requested. 9 However, if the Practice agrees to a requested restriction, then the restriction is binding on the Practice. 10

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for *all future* transactions, with the understanding that any such revocation will not apply to the extent that the Practice has already taken action in reliance on this consent. 11

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me. 12

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me. 13

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.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(e.g., Attorney-in-Fact, Guardian, Parent if a minor):

Relationship

Date Signed // Witness:

(NEW YORK STATE CHIROPRACTIC ASSOCIATION AND HARTER, SECREST & EMERY, LLP, ROCHESTER, NEW YORK)