Welcome to CenterPoint Chiropractic
New Patient Paperwork

"Health begins in youth. As a chiropractic physician, it is my hope to enlighten my patients on how chiropractic care will improve their lives and the lives of the generations to come. My goal is to fill the needs of my patients and give them the information necessary to take greater control over their own health care. I am excited about the future of healthcare and look forward to translating new knowledge into meaningful advances." –Kristina Clay, D.C.

Patient Demographic Information

Name (First)_____ (MI) _____ (Last) _____

What do you prefer to be called? _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ May we leave a message at this number? □ Yes □ No

Work Phone _____ May we leave a message at this number? □ Yes □ No

Cell Phone _____ May we leave a message at this number? □ Yes □ No

Email Address _____ Opt Out of Email □

Gender: □ Female □ Male Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Date of Birth _____ Social Security Number _____

How did you hear about our office or who referred you? _____

Employment Status: □ Employed □ Unemployed □ Retired □ Part-Time Student □ Full-Time Student

Your Employer _____ Occupation _____

Business Address _____ City/State/Zip _____

HIPAA Privacy Requirements

Our practice defines 'personal health information' as any information that is protected under the HIPAA Privacy Rule. It includes, but is not limited to, all appointment information, lab/test results, etc. We will NOT disclose ANY of your personal health information to anyone that is not listed below. Due to the fact that we must have your permission in writing, we will not be able to take verbal verification later. Therefore, please list the names of anyone that you give permission to access your personal health information on the lines below.

Name _____ Relationship_____ Phone Number _____

Name _____ Relationship_____ Phone Number _____

Name _____ Relationship_____ Phone Number _____

Emergency Contact _____ Relationship _____ Phone Number _____

Do you want to allow your emergency contact person access to your personal health information? □ Yes □ No

Primary Care Physician _____ Phone Number _____

May we discuss your medical information with your primary care physician? □ Yes □ No

Patient name & DOB _____

Do you have health insurance? □ Yes □ No Do you have secondary health insurance? □ Yes □ No

Responsible Party Information (if other than patient) – Must be completed for all patients under the age of 18

Name of Person Responsible for Payment _____ Relationship to Patient _____

Address _____ City/State/Zip _____

Phone Number _____ Date of Birth _____ Social Security Number _____

Primary Insurance Information – Only complete if insurance is in anyone's name <u>other</u> than the patient.

□ Same as responsible party

Name of Insured _____ Relationship to Patient _____

Address _____ City/State/Zip _____

Phone Number _____ Date of Birth _____ Social Security Number _____

Secondary Insurance Information – Only complete if insurance is in anyone's name <u>other</u> than the patient.

□ Same as responsible party

Name of Insured _____ Relationship to Patient _____

Address _____ City/State/Zip _____

Phone Number _____ Date of Birth _____ Social Security Number _____

Is this visit a result of a Work Comp Injury? □ Yes □ No
Is this visit a result of a Motor Vehicle Accident? □ Yes □ No
Is this visit the result of a Liability Accident? □ Yes □ No
If any of the above three questions were answered YES, please go see the receptionist immediately. Thank you!

Attorney Information

Name of Attorney: _____

Address of Attorney:_____

Phone Number of Attorney: _____

Patient's Vehicle Insurance Information

Ins. Company Name: _____

Agents Name: _____

Name on Policy: _____

Policy #: _____ Claim #_____

Medical Pay Coverage: _____

Responsible Party's Vehicle Insurance Information

Ins. Company Name: _____

Address: _____

Phone Number: _____

Name on Policy: _____

Policy #: _____ Claim # _____

Patient name & DOB _____

CONSENT TO TREAT: I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity. _____ (patient initials)

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of medical benefits furnished to me by the chiropractor(s) of CenterPoint Chiropractic. I understand I am financially responsible for any amount (1) not covered by my insurance company, HMO, POS or PPO and (2) if my insurance company requires a referral and I have not obtained the referral prior to services being rendered. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. _____ (patient initials)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize CenterPoint Chiropractic to release any information acquired in the course of my examination and/or treatment to: (1) my insurance company(ies), (2) to any physician who has referred me for treatment, and (3) to any physician to whom I may subsequently be referred. Also, I give permission to CenterPoint Chiropractic and/or staff to release information (verbal or written) about me, my medical condition and/or treatment to the people listed above under the HIPAA Privacy Requirements section. _____ (patient initials)

CONTACT RELEASE INFORMATION: I agree to permit CenterPoint Chiropractic and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile device concerning any and all aspects of my account: financial, procedural or scheduling. I also give permission to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office. _____ (patient initials)

PRIVACY POLICY: I realize that I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. _____ (patient initials)

To the best of my ability, the information I have supplied is complete and truthful. I attest that I have read and understand the policies of CenterPoint Chiropractic, and accept my responsibility as stated in those policies. _____ (patient initials)

Patient Signature: _____DOB_____ Date _____

17 years of age and under required signature of Parent/Guardian/Responsible Party

Chief Complaint

Patient name & DOB _____

Reason for your visit? _____

When did you first notice the symptoms? _____

Is this condition getting progressively worse? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Other_____

Pain aggravated by: ☐ Coughing ☐ Sneezing ☐ Straining ☐ Bowel Movement

☐ Neck Flexion ☐ Neck Extension ☐ Neck Rotation ☐ Neck Lat. Flexion

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Rate the severity of your pain from 0 (no pain) to 10 (constant severe pain – incapacitated): _____

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other

Name and address of other doctor(s) who have treated you for your condition:

_____

Have you had x-rays taken? □ Yes □ No When? _____ Where? _____

Current Review of Symptoms

Dates of last medical exams: _____

Current Medications: _____

Drug Allergies: _____

Other Allergies: _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Are you currently trying to become pregnant? ☐ Yes ☐ No Date of last menstrual cycle

_____

Please check all symptoms that you are ***currently*** experiencing.

- □ Anxiety
- □ Asthma/Wheezing
- □ Blood in Urine
- □ Blurred Vision
- □ Bronchitis
- □ Change in Voice
- □ Chest Pain
- □ Constipation
- □ Depression
- □ Diarrhea
- □ Dizziness
- □ Edema/Swelling
- □ Fatigue
- □ Fever
- □ Foot/Ankle Swelling
- □ Frequent Urination
- □ Gait Abnormality
- □ Glaucoma
- □ Headache
- □ Hearing loss
- □ Heat/Cold Intolerance
- □ Hormone Replacement
- □ Incontinence
- □ Insomnia
- □ Joint Pains
- □ Kidney Stones
- □ Loss of Appetite
- □ Lumps
- □ Memory Loss/Confusion
- □ Muscle Pain/Cramps
- □ Muscle Weakness
- □ Nausea
- □ Nose Bleeds
- □ Painful Urination
- □ Rash
- □ Ringing in Ears
- □ Shortness of Breath
- □ Sore Throat
- □ Tingling/Numbness
- □ Varicose Veins
- □ Vomiting
- □ Weight Change
- □ Other _____

Daily Habits

Tobacco Use: ☐ Never ☐ Former (Quit Date: _____) ☐ Current (# of Cigarettes/day _____) ☐ Smokeless Tobacco

Water Consumption: ☐ Never ☐ Yes: _____ drinks per day/week (circle one)

Coffee or Caffeinated Beverage Use: ☐ Never ☐ Yes: _____ drinks per day/week (circle one)

Alcohol Use: ☐ Never ☐ Yes: _____ drinks per day/week (circle one)

Recreational Drug Use: ☐ Never ☐ Not Currently ☐ Yes (Please Specify _____)

What type of exercise do you perform on a daily basis? ☐ None ☐ Light ☐ Moderate ☐ Heavy

What do your daily work habits include? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Computer Work

What vitamins do you take? _____

What kind of other nutritional supplements do you take, if any? _____

Medical Diagnosis

Patient name & DOB _____

Please check any disease/conditions that you personally have had.

- □ AIDS/HIV
- □ Alcoholism
- □ Allergy Shots
- □ Alzheimer's Disease
- □ Anemia
- □ Anorexia
- □ Anxiety
- □ Appendicitis
- □ Arthritis
- □ Asthma
- □ Bleeding Disorders
- □ Breast Lump
- □ Bronchitis
- □ Bulimia
- □ Cancer
- □ Cataracts
- □ Chemical Dependency
- □ Chicken Pox
- □ Depression
- □ Diabetes
- □ Eczema
- □ Emphysema
- □ Epilepsy
- □ Fractures
- □ Glaucoma
- □ Goiter
- □ Gonorrhea
- □ Gout
- □ Heart Disease
- □ Hepatitis
- □ Hernia
- □ Herniated Disc
- □ Herpes
- □ High Blood Pressure
- □ High Cholesterol
- □ Influenza
- □ Kidney Disease
- □ Liver Disease
- □ Measles
- □ Mental Disorder
- □ Migraine Headaches
- □ Miscarriage
- □ Mononucleosis
- □ Multiple Sclerosis
- □ Mumps
- □ Osteoporosis
- □ Pacemaker
- □ Parkinson's Disease
- □ Pinched Nerve
- □ Pleurisy
- □ Pneumonia
- □ Polio
- □ Prostate Problems
- □ Prosthesis
- □ Psychiatric Care
- □ Rheumatoid Arthritis
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Sleep Apnea
- □ Stroke
- □ Suicide Attempt
- □ Thyroid Problems
- □ Tonsillitis
- □ Tuberculosis
- □ Tumor, Growths
- □ Typhoid Fever
- □ Ulcers
- □ Vaginal Infections
- □ Venereal Disease
- □ Whooping Cough
- □ Other _____

_____

_____

_____

_____

Have you had any broken bones? ☐ Yes ☐ No If yes, please list and give dates _____

To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? ☐ Yes ☐ No If yes, please explain _____

Past Surgical History

Date:	Procedure:
_____	_____
_____	_____
_____	_____

Family Medical History

Medical Conditions/Diseases (Diabetes, Cancer, Heart Disease, Back Pain, etc.)

Father _____

Mother _____

Siblings _____

Children _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed.

Patient Signature: _____DOB_____ Date _____

17 years of age and under required signature of Parent/Guardian/Responsible Part

Patient name & DOB _____

Auto Related Accident Form

Date of Accident: _____ Time of Accident: _____ ☐ a.m. ☐ p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger

If a traffic violation was issued, to whom was it issued? _____

Number of people in accident vehicle: _____

Did the police come to the accident site? ☐ Yes ☐ No

Was a report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing your seatbelt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No If yes, did they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐ Another vehicle ☐ Other _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No If Yes, please describe:

_____

_____

Make & model of the vehicle you were occupying:

_____

Name of the location/street on which you were traveling:

_____

In which direction where you headed? ☐ N ☐ S ☐ E ☐ W

What was the approximate speed of your vehicle? _____ mph

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Right ☐ Left ☐ Other

During impact, were you facing? ☐ Right ☐ Left ☐ Forward

Were you aware or surprised by the impact? ☐ aware ☐ surprised

In your words, please describe the accident:

_____

_____

_____

If the accident vehicle made impact with another vehicle...

Make & mode of that other vehicle:

_____

Direction other vehicle was heading: ☐ N ☐ S ☐ E ☐ W Speed of other vehicle:_____ mph ☐ Unknown

After Accident

Did the accident render you unconscious? ☐ Yes ☐ No If Yes, for how long? _____

Please describe how you felt immediately after the incident:

_____

Have you gone to a hospital or seen any other Doctor? ☐ Yes ☐ No

When did you go? ☐ Just after accident ☐ Next day ☐ Two days or longer

How did you get there? ☐ Ambulance ☐ Private Transportation

Name of hospital and/or attending doctor:

_____

Was he/she a: ☐ D.C. ☐ M.D./D.O. ☐ Unknown ☐ Other:

Patient name & DOB _____

Describe any treatment you received:

_____

_____

Were x-rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes & Goes

Indicate the symptoms that are a result of this accident? Check all that apply.

☐ Dizziness ☐ Difficulty Sleeping ☐ Jaw Problems ☐ Nausea ☐ Memory Loss ☐ Irritability ☐ Arms/Shoulder Pain ☐ Back Pain

☐ Headache(s) ☐ Low Back Pain ☐ Numb Hands/Fingers ☐ Fatigue ☐ Blurred Vision ☐ Tension ☐ Back Stiffness ☐ Chest Pain

☐ Buzzing in the Ear ☐ Neck Pain ☐ Shortness of Breath ☐ Leg Pain ☐ Ears Ringing ☐ Numb Feet/Toes ☐ Stomach Upset

☐ Neck Stiffness ☐ Other:

_____

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on Back	☐	☐	☐
Lying on Side	☐	☐	☐
Lying on Stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Lovemaking	☐	☐	☐
Walking	☐	☐	☐
Lifting	☐	☐	☐
Bending	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐

Recovery

To evaluate the effect that continuing to work will have on your recovery, please complete the following:

How many hours are in your normal workday? _____

Please indicate your daily job duties and any activities which you are occasionally asked to perform.

☐ Standing ☐ Driving ☐ Operation of Equipment ☐ Sitting ☐ Twisting ☐ Work with arms above head ☐ Walking ☐ Crawling ☐ Typing ☐ Lifting ☐ Bending

☐ Stooping ☐ Other: _____

What positions can you work in with minimal physical effort and for how long? _____

☐ N/A

Prior to the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A

CenterPoint
chiropractic, acupuncture and nutrition

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION ("AGREEMENT")

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or to other legal entities ("payers"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("condition"), to pay directly to, and exclusively in the name of, CenterPoint Chiropractic such sums as may be owing to CenterPoint Chiropractic for charges incurred by me, including but not limited to, charge for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at this office. I further grant a contractual lien to CenterPoint Chiropractic with respect to my charges, applicable to all payers, however, I understand that nothing in this Agreement shall be construed as an election by CenterPoint Chiropractic to claim protection under any statutory lien law. For the purpose of this Agreement, "benefits" shall include, but shall not be limited to, proceeds from settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payee is benefits, personal injury protection, lost wages benefits, lost service benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay CenterPoint Chiropractic, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to CenterPoint Chiropractic to extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name or in the Office's name, and to settle or to otherwise resolve such causes, of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issuer a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice to this Office regarding any funds received by the attorney relating to my accident, to promptly pay such Office, and to provide a full accounting of such funds to this Office upon its request.

I hereby direct all payers to release to CenterPoint Chiropractic any information regarding any coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize CenterPoint Chiropractic to endorse/sign my name on any and all checks listing me as a payee, which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize CenterPoint Chiropractic to apply any credit balance on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due to CenterPoint Chiropractic for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect any outstanding balance on my account, I will be responsible for payment and will reimburse CenterPoint Chiropractic for all cost of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual consent of CenterPoint Chiropractic and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interest of CenterPoint Chiropractic and myself. However, should any provisions of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, neverless, remain in full force and effect.

Patient Name (please print)_____

Patient/ Signature_____ Date:_____

Name of Custodial Parent or Legal Guardian (please print) _____

Parent/Guardian Signature_____ Date:_____

Financial Policy, Patient Bill of Rights and Responsibilities for Personal Injury

Thank you for choosing CenterPoint Chiropractic as your healthcare provider. We are committed to providing excellent healthcare services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy. All patients must read and sign this form prior to receiving services. It is your responsibility to provide us with your most current insurance information.

1. If you do not have health insurance, or your health insurance does not have chiropractic benefits, you are financially responsible for the full amount of services rendered.

2. We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.

3. If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for the full amount of services rendered.

4. Please be aware that some or perhaps all of the services may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.

5. Before receiving services, you should verify that we are participating providers for your insurance company. It is also necessary that if you are a participant in an HMO plan you must obtain an insurance referral from your primary care physician listed on your insurance card before you are seen by another healthcare provider.

6. Co-payments must be collected at the time of service. This is a requirement set by your insurance company. No exceptions.

7. You must provide your most current billing address, all available telephone numbers and any other important contact information and if any of this changes, it is your responsibility to contact us with the updated information.

8. Med pay is an extra health insurance endorsement on your auto insurance. It is something you may or may not have chosen to purchase with your auto insurance plan. It usually has a payable cap depending on what you bought. It will not raise your insurance rates if you chose to utilize this form of payment. This is exactly how the endorsement is meant to be used. The benefit of using your med pay that your services here paid for along the way and you are less likely to accrue large sum waiting on liable party.

9. Although you are ultimately responsible for your bill, it is our office policy to allow 90 days after you have been dismissed from care for the claim to be settled with the liability company. Once the 90 days is reached, if no settlement has been made, we require the patient to start making payments towards their personal injury case in order to avoid further action/collections.

Please initial one statement below on how you would like us to bill your visits here:

_____ I would like to use my medical health insurance. I know that I will be responsible for paying my co-pay/deductibles at the time of service. I know that I will be financially responsible for any charges that insurance does not cover.

_____ I would like to use my med-pay benefits through my auto insurance. I know that I will be responsible for any charges that exceed my med pay benefits. (see #8 above)

_____ I would like to wait and file all charges with the liable party after I have been dismissed from care. I understand the 90 day office policy (see #9 above) and that I am ultimately responsible for all accrued charges.

By signing below you acknowledge that you have read the Financial Policy and fully understand its terms.

Print Patient Name _____ Date: _____

Patient/Responsible Party Signature _____

Please notify your auto insurance carrier of your visit to our office immediately. We will submit to your medical insurance only if applicable. **We collect 100% of our fees for personal injury or automobile accidents**. If any of your medical or account information has changed, please inform our front desk personnel immediately. Please remember you are ultimately responsible for your account.

Print Patient Name _____ Date: _____

Patient/Responsible Party Signature _____