Welcome to Phillips Family Chiropractic

Name: ________________________________ Age: ______ DOB: _____/_____/______ SS# _____/____/______

Address: ____ City: _____________________ State:_________

Zip Code:___________ Phone: (______)_______-__________ Employer: ______________________________

Occupation: _____________________________ **Circle One**: Single / Married Number of Children: ______

Email: _________________________________ Spouse: __________________ Employer: __________________

Referred? _____________________Emergancy Contact: ______________________ Phone: (____)_____-_______

Primary Insurance: __________________________________ Eff. Date: ____________ Group # : _____________

Secondary Insurance: ________________________________ Eff. Date: ____________ Group # : _____________

Statement of consent

I consent to any physical examination, x-ray, Laboratory procedures, chiropractic or adjustive therapy or clinic service that is ordered under the general and specific instructions of the doctor. I also consent to pay all legal and collection fees (33%) necessary for the collection of my account.

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

I _________________________, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. Phillips Family Chiropractic, L.L.C. (PFC) Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for PFC to provide treatment to me, and also necessary for PFC to obtain payment for that treatment and to carry out health care operations. PFC explained to me that the Privacy Notice will be available to me in the future at my request. PFC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. PFC reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by PFC:
   A. Telephoning my home and/or office and leaving a message on my answering machine or with the individual answering the phone.
   B. Birthday cards, thank you grams, and/or patient information publications.
   C. Other health-related benefits or services that may be of interest to me.
4. PFC may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for PFC to treat me and obtain payment for that treatment, and as necessary for PFC to conduct its specific health care operation.
5. I understand that I have a right to request that PFC restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operation. However, PFC is not required to agree to any restrictions that I have requested. If PFC agrees to a request restriction, then the restriction is binding on PFC.
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 shall not apply to the extent that PFC has already taken action in reliance on this Consent.

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** **Date ____/____/____**

Phillips Family Chiropractic

Office Financial Policy

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
3. We accept assignment for the initial treatment plan only. Any follow up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.
4. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
5. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine if proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into this office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue an over payment check—it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as a balance is due.
6. Any services not covered or coverage reductions by your insurance will be the patient's responsibility along with any and all costs of collecting past due accounts.
7. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company, If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and will be the responsibility of the patient.
8. If you have any questions concerning this or any other matter, please speak with the insurance department prior to seeing the doctor.
9. You are responsible for all legal and collection fees added to overdue account balances.

I have read and understand the Financial Policy and agree to abide by these terms.

Patient (Legal Guardian) Signature____________________________________ Date _______________

Grayson K. Phillips D.C. 600 Main Street Gardendale, AL. 35071 (205) 631-8808

Phillips Family Chiropractic New Patient History

REASON FOR VISIT

What is the reason for your visit today? □ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □Other________________ **What caused this complaint(s)?**

____

____

When did this complaint begin? ______/______/______ **Is it getting worse?** □ Yes □ No □ Constant □ Comes and goes

Have you had this or similar complaint in the past? □ Yes □ No If "Yes", when?________________

What does your complaint (s) feel like? **Circle all** that apply: *Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing /*

*Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other*_____________________________________

What aggravates this complaint? Circle all that apply: Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other:____

What relieves this complaint? Circle all that apply: Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Laying down / Medication / Nothing / Unknown / Other:________________________

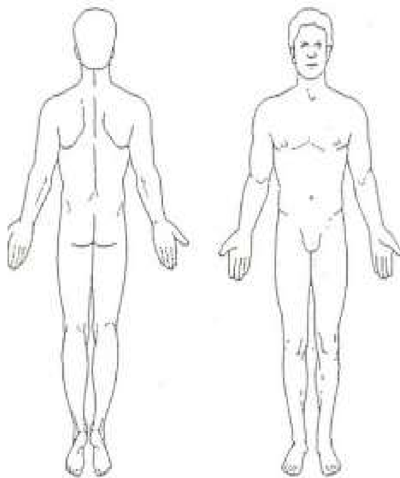
How often do you experience your symptoms? □ 25% of the day □ 50% of the day □ 75% of the day □ 100% of the day **Timing of complaint: Check appropriate box:** □ Morning □ As day progresses □ Afternoon □ Evening □ While sleeping □ During activities □ After activities □ Symptoms are constant and do not change □Other:___________________________________

With time are your symptoms: □ Improving □ Worsening □ Not changing

Have you seen other doctors for this complaint? □ Yes □ No If "Yes", please provide the following information: Doctor's name:______________________________

Date consulted:____________________Diagnosis___________________________

Is this condition interfering with your: (Circle all that apply) Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other:___________________



←Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.

Area for doctor's notes:

On the scale below, please circle the severity of your main complaint right now:

No Pain ***Moderate Pain*** ***Worst Possible Pain***

0	1	2	3	4	5	6	7	8	9	10

Is your complaint interfering with your daily activities? □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

HEALTH HISTORY

Please check **ALL** of the health conditions below that apply to **you** currently or in the past.				**Family History** Mark **ALL** conditions that run in your family		Relationship: (Father,Mother,Sister,Brother)
☐	Osteoarthritis/Degenerative Joint Disease	☐	Whiplash Injury *Date of injury:*	☐	Cancer *Type:*	
☐	Asthma	☐	Headaches	☐	Anemia	
☐	Diabetes ☐ Type I ☐ Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? ☐ Yes ☐ No ☐ Not Sure	☐	Joint Pain (Circle location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other:___________	☐	Diabetes (check one) ☐Type I ☐ Type II	
☐	Anemia	☐	Migraines	☐	Heart Problems / Stroke	
☐	Cancer/Tumor	☐	Osteoporosis /Osteopenia	☐	High Blood Pressure	
☐	Rheumatoid Arthritis	☐	Epilepsy / Seizures	☐	Genetic Disorders	
☐	Depression/ Anxiety	☐	Fibromyalgia / Chronic Fatigue	☐	Rheumatoid Arthritis	
☐	Disc Herniation	☐	Genetic Disorders	☐	Other (List):	
☐	High Blood Pressure /Hypertension	☐	Please list any other medical conditions:			
☐	Heart Disease / Stroke					

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

____

____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

____

____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ☐ Yes ☐ No

List current prescription medications, including frequency and dosage if known. **If there are NO current medications, check here** ☐

Name of prescription medication	*Dosage/Start date*	4.	
1.		5.	
2.		6.	
3.		7.	

List any know <u>allergies you have had to prescription medications</u>. If NO medication allergies are known, check here ☐

1.____ 2.____

SOCIAL HISTORY

Height Ft. In. **Weight:** Lbs..

Do you exercise? ☐ Yes ☐ No **Times per week?** **Intensity?** ☐ Light ☐ Moderate ☐ Strenuous Type?:

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐ Never been a smoker
If "Yes", how often do you smoke: ☐ Current every day smoker ☐ Current sometimes smoker **Circle level below ↓:**
If "Yes", what is your level of interest in quitting smoking? (0 = NO interest, 10=very interested) **0 1 2 3 4 5 6 7 8 9 10**

Do you drink alcohol? ☐ Yes ☐ No **How many drinks per week?** **For how many years?**

Do you drink caffeine? ☐ Yes ☐ No **How many drinks per day?** **What type?** ☐ Coffee ☐ Tea ☐ Soft Drinks ☐ Energy Drinks

Do you take pain killers? ☐ Yes ☐ No **How often?** ☐Daily ☐ Weekly ☐ Monthly ☐ Rarely **What type?** ☐ Aspirin ☐ Ibuprofen ☐ Tylenol ☐ Other___________________________

What do your work duties include? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Other:

Please describe your overall health right now? ☐ Excellent ☐ Very Good ☐ Good ☐Fair ☐ Poor

What is your current stress level? ☐ Mild ☐ Moderate ☐ High

Have you seen a chiropractor in the past? ☐ Yes ☐ No

What are your hobbies?

INFORMED CONSENT

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

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible “pop” or “click, “ much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, your are consenting to the following procedures:

- spinal manipulative therapy
- palpation
- vital signs
- range of motion testing
- orthopedic testing
- basic neurological testing
- muscle strength testing
- postural analysis
- EMS
- ultrasound
- hot/cold therapy
- radiographic studies
- Other (please explain)____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatments. I 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 my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

1-Self-administered, over-the-counter analgesics and rest 2-Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers 3-Hospitalization 4-Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE “BOX” AND SIGN BELOW:

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor of Chiropractic at Phillips Family Chiropractic and have had my questions answered to my satisfaction. I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at Phillips Family Chiropractic, responsible for any errors or omissions that I may have made in the completion of this form. 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.

Dated:___/___/____

______________________________	______________________________
Print Patient’s Name	Signature of Patient