

FRUITPORT CHIROPRACTIC CENTER

3427 Farr Road - Fruitport, MI 49415 - www.fruitportchiropractic.com
(231) 865-6545 - Fax: (231) 865-6212 - e-mail: drsteve@fruitportchiropractic.com

Informed Consent for Chiropractic Care

A patient, incoming to the Chiropractic Physician, gives the Doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The Doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures, whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice, and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Fruitport Chiropractic Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient's Signature _____ Date _____

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree and how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy, and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used, and I agree to these policies and procedures.

Patient's Signature _____ Date _____

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CHIROPRACTIC CASE HISTORY & PATIENT INFORMATION

Date _____ Patient Number _____

Name _____ SSN _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

E-mail address _____ Cell Phone No. _____

Age _____ Birth Date _____ Race _____ Marital Status: M S W D How many children? _____

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____

Spouse _____ Occupation _____ Employer _____

Name of Nearest Relative (Emergency contact) _____

Address _____ Phone _____

How were you referred to our office? _____

Family Medical Doctor _____ Phone _____

Purpose of this appointment _____

Date symptoms appeared or accident happened _____

Have you ever had the same or a similar condition? Yes No If yes, when? _____

Please describe _____

Days lost from work _____ Date of last physical examination _____

What surgeries have you had? (Include dates) _____

Continued: _____

Serious illnesses (include dates) _____

Continued: _____

Have you been treated for any health condition by a physician in the last year? Yes No If yes, describe _____

What medications or drugs are you taking? _____

Please check any and all insurance coverage that may be applicable in this case:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident Other

Name of Primary Insurance Company _____

Name of Secondary Insurance Company (if any) _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or Chiropractic office. I understand and agree to allow this Chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of Chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

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1. What is your major symptom? _____
2. If this is a recurrence, when was the first time you noticed this problem? _____
How did it originally occur? _____
Has it become worse recently? Yes No Same Better Gradually Worse
If yes, when and how? _____
3. How frequent is the condition? Constant Daily Intermittent Night only
How long does it last? All day Few hours Minutes
4. Are there any other conditions or symptoms that may be related to your major symptom?
Yes No If yes, describe _____
5. Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing
Other _____
6. Is there anything you can do to relieve the problem? Yes No If yes, describe _____
_____ If no, what have you tried to do that has not helped? _____

7. What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting
Other _____
8. Have you had any broken bones? Yes No If yes, please list and give dates _____

9. List any major accidents you have had other than those that might be mentioned above: _____

10. 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 _____

11. WOMEN ONLY: Are you pregnant, or is there any possibility you may be pregnant? Yes No Uncertain
12. Remarks: _____

13.

NO SYMPTOMS	EXTREME SYMPTOMS

Please place an "X" on the line above to indicate your level of problem.

Doctor's Signature _____ Date _____

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Name _____ Date _____

**Please check "Y" (yes) or "N" (no) if you have had any of the following symptoms:
 (Please circle your answer)**

Recent weight loss or weight gain	Y	N	
Rashes, Hives, Lesions	Y	N	_____
Hay fever or post-nasal drainage	Y	N	_____
Chest pain or palpitations	Y	N	_____
Shortness of breath, wheezing or coughing	Y	N	_____
Nausea, vomiting, or diarrhea	Y	N	_____
Urinary frequency or urgency	Y	N	_____
Lymphadenopathy polydypsia	Y	N	_____
Polyua or polydypsia	Y	N	_____
History of seizures of headaches	Y	N	_____

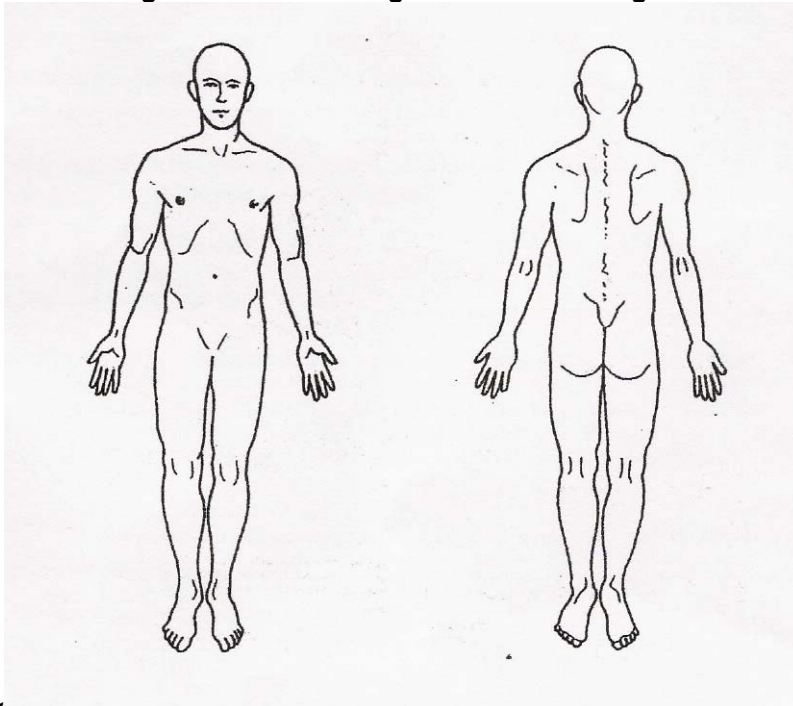
Tobacco Use	None	Light	Moderate	Heavy
Alcohol Use	None	Light	Moderate	Heavy
Drug Use	None	Light	Moderate	Heavy
Exercise	Never	Seldom	Occasionally	Regularly

TELL US WHERE YOU HURT

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>>> Numbness ===== Pins & Needles o o o o o
 Burning x x x x Stabbing ///// Throbbing ~ ~ ~ ~



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Insurance Questionnaire

The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.

1. Type of insurance: Medicare Medicaid Group Health Plan Other
2. Insured's ID Number _____
3. Patient's Name _____
4. Insured's Name (as it appears on the insurance card) _____
5. Insured's date of birth _____ SSN _____ Male Female
6. Insured's employer or school name _____
City _____ State _____ Zip _____ Phone # _____
7. Insured's address (if same as patient, put "same") _____
City _____ State _____ Zip _____ Phone # _____
8. Patient's status: Single Married Other Employed Full-time student Part-time student
9. Is the condition we are treating related to current or previous employment? Yes No
10. Is the condition we are treating related to an auto accident? Yes No
11. Is the condition we are treating related to another type of accident? Yes No
12. Is there another health benefit plan? Yes No If yes, list: _____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: _____ Date: _____

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to _____ for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance, and understand that I am ultimately responsible for payment in full at this office.

Signed: _____ Date: _____

MEDICARE ONLY

All doctors have been instructed to ask the following questions of all Medicare patients.

1. Do you or your spouse work for a company that provides you with health insurance? Yes No
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes No
3. Is the illness or injury the result of an accident or illness that occurred at work? Yes No
4. Is this illness or injury the result of an accident or other injury? Yes No
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes No
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes No
7. Do you have a Medicare Medigap Policy? Yes No
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from) Yes No

