

# FRUITPORT CHIROPRACTIC CENTER

3427 Farr Road - Fruitport, MI 49415 - [www.fruitportchiropractic.com](http://www.fruitportchiropractic.com)  
(231) 865-6545 - Fax: (231) 865-6212 - e-mail: [drsteve@fruitportchiropractic.com](mailto: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 \_\_\_\_\_

## ***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 \_\_\_\_\_

# FRUITPORT CHIROPRACTIC CENTER

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

## 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** \_\_\_\_\_

# FRUITPORT CHIROPRACTIC CENTER

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

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. 

<b>NO SYMPTOMS</b>	<b>EXTREME SYMPTOMS</b>
_____	

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

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

# FRUITPORT CHIROPRACTIC CENTER

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

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 or headaches	Y	N	_____

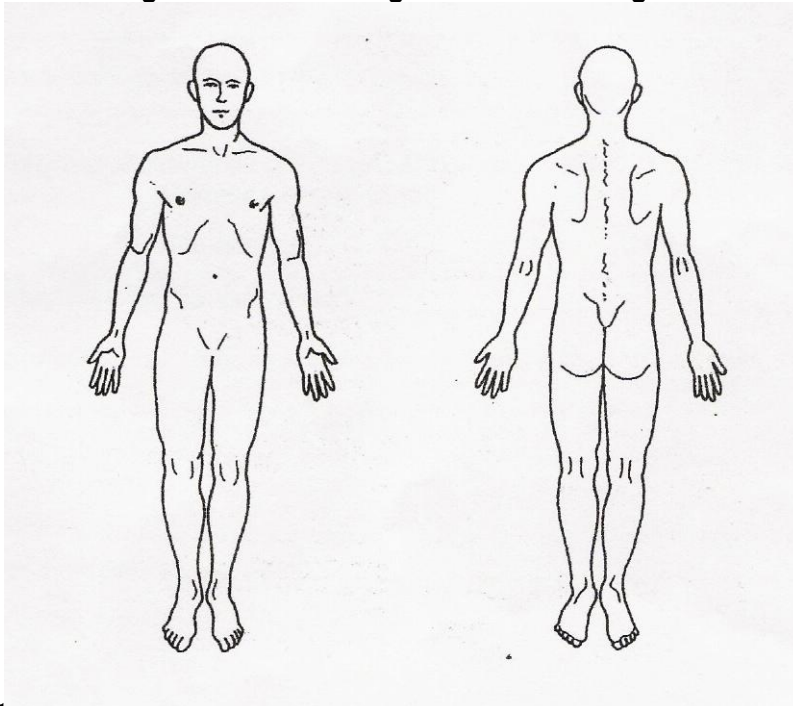
Tobacco Use	None	Light	Moderate	Heavy
Alcohol Use	None	Light	Moderate	Heavy
Drug Use	None	Light	Moderate	Heavy
Exercise	Never	Seldom	Occasionally	Regularly

## 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 ~ ~ ~ ~**



# FRUITPORT CHIROPRACTIC CENTER

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

## 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