ALIGNED CHIROPRACTIC

New Patient Paperwork

*** Please be ready to provide your driver's license and insurance cards for our records ***

Patient Information:

Name: *(First, MI, Last)*_____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: *(MM/DD/YYYY)* _____ Gender: ☐ Male ☐ Female SSN#: _____

Email: _____

Phone Number: _____ ☐ Cell ☐ Home ☐ Work

Preferred Notification Method: *(Used ONLY for appointments and/or care)*

☐ Call ☐ Email ☐ Text/SMS Message: *(Please specify carrier)* _____ ☐ Mail

How did you find out about us?:

Physician: _____ Insurance: _____

Family or Friend *(name)*: _____ Internet: _____

Other *(please specify)*: _____

****** FOR MINORS ONLY **** (if not, please skip)**

Parent or Legal Guardian Name: _____

Phone Number: _____ ☐ Cell ☐ Home ☐ Work

Marital Status: (*please circle)*

Single / Married / Divorced / Widowed / Other

Insurance: *(ONLY fill out if you are unable to provide your cards)*

Primary Company Name: _____ ID #: _____

Secondary Company Name: _____ ID #: _____

Note:We need all information to allow Coordination of Benefits or payor may deny.

Present Complaint History:

Please indicate the reason(s) for coming into the office today:

1. Primary Complaint: _____ When did it begin?: _____
2. Secondary Complaint(s):
   - _____ When did it begin?: _____
   - _____ When did it begin?: _____
   - _____ When did it begin?: _____

Did something specific happen? *(ie. Trauma, Accident, Fall, Illness)*:

_____

_____

Are there any daily activities that are being affected by the complaint(s)? *(ie. Personal Care, Work, Sleeping, Cleaning, etc.)*:

_____

_____

Have you received any previous treatment for the complaint(s)? (*please circle)*

Chiropractor / Medical Doctor / Physical Therapy / Emergency Room / Urgent Care / Orthopedic / None

Other (please specify: _____

Have you had any previous diagnostic testing performed? (*please circle)*

X-rays / MRI / CT Scan / None

Other: *(please specify)*: _____

Current Medications and Supplements: *(if taking none, please leave blank) – You may also provide a list to be scanned into your file*

1. _____ Dosage _____ Frequency _____ Reason _____
2. _____ Dosage _____ Frequency _____ Reason _____
3. _____ Dosage _____ Frequency _____ Reason _____

Social History:(*please circle)*

Employed? No / Retired / Student / Yes *(please specify)* _____

Caffeine Use: No / Yes (*if so, how much daily?*) _____

Smoking/Tobacco Use: Every Day / Occasional / Former / Never

Exercise: Daily / 3-4 times per week / 2-3 per week / Rarely / Never

Alcohol Use: Every Day / Weekly / Occasional / Never

Review of Systems: *(please check any of the following that **have affected** or **are currently affecting** you)*

□ ***Skin Disease or Cancer:***
○ Melanoma;
Date (Est:)_____
Location: _____
○ Squamous Cell Carcinoma
○ Basal Cell Carcinoma
○ Actinic Keratosis (pre-skin cancer)
○ Other: _____
□ ***Dermatological Disease:***
○ Herpes/Cold Sores
○ Psoriasis
○ Eczema
○ Acne
○ Rosacea
○ Blistering Disorder: _____
○ Healing problems: (slow, keloid, bruising)
○ Other: _____
□ ***Immunological Disease:***
○ Immune deficiency
○ HIV/AIDS
○ Lupus or Scleroderma
□ ***Hematology/Oncology:***
○ Cancer; type: _____
○ Location: _____Year: _____
○ Remission: Yes / No
○ Bleeding Problems
□ ***Rheumatologic Disease:***
○ Osteoarthritis/Arthritis
○ Rheumatoid Arthritis
○ Gout
□ ***Psychological/Emotional Disease:***
○ Depression
○ Obsessive-Compulsive
○ Nervousness/Anxiety
○ Sleep Problems
□ ***Gastrointestinal Disease:***
○ Crohn's Disease, Ulcerative Colitis
○ Esophageal Reflux
○ Peptic Ulcer
○ Esophagitis
□ ***Orthopedic Disease:***
○ Artificial Joint _____(area)
○ When? _____

□ ***Cardiovascular Disease:***
○ High Blood Pressure
○ Heart Problems; _____
○ Heart Attack; Date: _____
○ **Pacemake**r
○ **Defibrillator**
○ Prostatic Heart Valve
○ Irregular Heartbeat
○ High Cholesterol
□ ***Endocrine Disease:***
○ Diabetes
○ Hyperthyroid
○ Hypothyroid
□ ***Neurological Disease:***
○ Stroke/Aneurysm
○ Seizure/Epilepsy
○ Multiple Sclerosis (MS)
○ Alzheimer's
○ Fainting
□ ***Liver Disease:***
○ Hepatitis: Type_____
○ Jaundice
□ ***Lung Disease:***
○ Asthma
○ COPD
○ Tuberculosis
□ ***Kidney Disease:***
○ Poorly functioning kidneys
○ Dialysis: Type_____
□***FOR FEMALE PATIENTS ONLY!!***
○ Polycystic Ovary Disease
○ Infertility
○ Nursing? Yes / No
○ Pregnant? Yes / No / Not sure
- If yes, when's the due date? _____
○ Are you <u>trying</u> to get pregnant? Yes / No
○ Last menstrual cycle: _____
□ ***Other/Not Listed:***
○ Transplant? Yes / No
○ What Type? _____
○ _____
○ _____
○ _____

Additional Information Dr. Campbell may need to be aware of:

Previous Injuries:

Have you ever had <u>any</u> of the following?*:*

Hospitalizations:

1. _____ Date: _____
2. _____ Date: _____

Surgeries: *(please circle side or both if applicable)*

Shoulder *(Right, Left, Both)*

Elbow/Forearm *(Right, Left, Both)*

Wrist/Hand *(Right, Left, Both)*

Hip *(Right, Left, Both)*

Knee *(Right, Left, Both)*

Ankle/Foot *(Right, Left, Both)*

Spinal Surgery *(Specify Area)* _____

Other: *(please specify)*: _____

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Family History:

Please check all that apply or circle <u>unknown</u> below

Unknown

	Mother	**Father**	**Sibling 1**	**Sibling 2**	**Sibling 3**	**Child 1**	**Child 2**	**Child 3**
Gender	F	M						
Age at death								
Aneurysms								
Stroke								
Cancer								
Diabetes								
Heart Disease								
High Cholesterol								
Hypertension								
Thyroid Issues								
Other								

DISCLOSURES OF MEDICAL INFORMATION TO FAMILY MEMBERS AND FRIENDS – (Please circle ONE)

- I hereby give my permission to disclose personal medical information about my treatment to the following individuals:

Name: _____ Relationship: _____ Phone #: (___) _____

Name: _____Relationship: _____ Phone #: (___) _____

- I do **NOT**give permission to disclose personal medical information about my treatment to family members or friends.
- I authorize release of medical information to my primary care, referring doctors and consultants **ONLY**!

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, AND FINANCIAL POLICIES

I. Consent for Treatment: I authorize ALIGNED CHIROPRACTIC PLLC, its agents, and DR. FELICIA CAMPBELL DC to render treatment to me/my dependents for Chiropractic and Therapeutic examinations and treatments. When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives. Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects, i.e. muscle spasms, stiffness, rib fracture, headache, dizziness, and stroke.

II. Assignment of Benefits/Release of Medical Information: I request that payment for authorized Medicare or other applicable private insurance benefits be paid directly to Aligned Chiropractic PLLC for services provided under their care. I also authorize Aligned Chiropractic PLLC to release necessary medical information to my insurance company, its agents, or any third party in order to determine payable benefits for the services rendered.

III. Financial Responsibility: I understand that I am ultimately responsible for any unpaid balance or non-covered service and am responsible for all costs of pursuing such balances if I fail to pay. (excludingany contractual agreements for ALIGNED CHIROPRACTIC PLLC and DR FELICIA CAMPBELL DC).

- *For patients17 and underwithout or forgoing insurance,we offer a group discount of 50% on services.Please call for more information on pricing.*

IV. Referrals/Authorization: I understand that if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of service, no services will be rendered until I obtain a referral or sign a waiver of financial responsibility. **Payment in full (co-payments and deductibles included) is required at the time of service.**

V. Missed Appointments: Our office requires 24-hour notice for cancellations.

VI. Authorization for X-Ray: I certify to the best of my knowledge I am not pregnant, my child is not pregnant, nor are there any known complicating limitations which would forbid taking x-rays. I understand that in the event x-rays are taken and require additional over-read, we will refer to a radiologist and I may incur an additional read fee.

I have reviewed the statements above and understand my responsibilities. If I don't, I agree that I can ask questions.

Patient/Legal Guardian Signature: *****_____*****

Date: _____

ALL PATIENTS PLEASE READ AND INITIAL

Receipt of Notice of Privacy Practices Written Acknowledgment Form:

I hereby acknowledge that I understand, that I have the opportunity to review, the privacy notice of health information practices (HIPAA – *see below* - full terms at request) of Aligned Chiropractic PLLC at any given time requested. *****_____***** (**PLEASE INITIAL**)

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have been advised about our full HIPAA compliance rules, regulations, and advisements notices before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcareoperations.
- The practice reserves the right to change the privacy policy as allowed bylaw.
- The practice has the right to restrict the use of the information, but the practice does not have to agree tothose restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will thencease.
- The practice may condition receipt of treatment upon execution of thisconsent.
- Patient/Guardian of patient has been advised through this document that full HIPAA compliance rules, regulations, and advisements notices for Aligned Chiropractic PLLC available at patient's request.

This consent was signedby:

Printed Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____