

# 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):

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

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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)*

<p><input type="checkbox"/> <b>Skin Disease or Cancer:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Melanoma; Date (Est:)<u>                    </u> Location: <u>                    </u></li> <li><input type="checkbox"/> Squamous Cell Carcinoma</li> <li><input type="checkbox"/> Basal Cell Carcinoma</li> <li><input type="checkbox"/> Actinic Keratosis (pre-skin cancer)</li> <li><input type="checkbox"/> Other: <u>                    </u></li> </ul> <p><input type="checkbox"/> <b>Dermatological Disease:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Herpes/Cold Sores</li> <li><input type="checkbox"/> Psoriasis</li> <li><input type="checkbox"/> Eczema</li> <li><input type="checkbox"/> Acne</li> <li><input type="checkbox"/> Rosacea</li> <li><input type="checkbox"/> Blistering Disorder: <u>                    </u></li> <li><input type="checkbox"/> Healing problems: (slow, keloid, bruising)</li> <li><input type="checkbox"/> Other: <u>                    </u></li> </ul> <p><input type="checkbox"/> <b>Immunological Disease:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Immune deficiency</li> <li><input type="checkbox"/> HIV/AIDS</li> <li><input type="checkbox"/> Lupus or Scleroderma</li> </ul> <p><input type="checkbox"/> <b>Hematology/Oncology:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cancer; type: <u>                    </u> <ul style="list-style-type: none"> <li><input type="checkbox"/> Location: <u>                    </u> Year: <u>            </u></li> <li><input type="checkbox"/> Remission: Yes / No</li> </ul> </li> <li><input type="checkbox"/> Bleeding Problems</li> </ul> <p><input type="checkbox"/> <b>Rheumatologic Disease:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Osteoarthritis/Arthritis</li> <li><input type="checkbox"/> Rheumatoid Arthritis</li> <li><input type="checkbox"/> Gout</li> </ul> <p><input type="checkbox"/> <b>Psychological/Emotional Disease:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Obsessive-Compulsive</li> <li><input type="checkbox"/> Nervousness/Anxiety</li> <li><input type="checkbox"/> Sleep Problems</li> </ul> <p><input type="checkbox"/> <b>Gastrointestinal Disease:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Crohn's Disease, Ulcerative Colitis</li> <li><input type="checkbox"/> Esophageal Reflux</li> <li><input type="checkbox"/> Peptic Ulcer</li> <li><input type="checkbox"/> Esophagitis</li> </ul> <p><input type="checkbox"/> <b>Orthopedic Disease:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Artificial Joint <u>                    </u> (area)</li> <li><input type="checkbox"/> When? <u>                    </u></li> </ul>	<p><input type="checkbox"/> <b>Cardiovascular Disease:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> High Blood Pressure</li> <li><input type="checkbox"/> Heart Problems; <u>                    </u></li> <li><input type="checkbox"/> Heart Attack; Date: <u>                    </u></li> <li><input type="checkbox"/> Pacemaker</li> <li><input type="checkbox"/> Defibrillator</li> <li><input type="checkbox"/> Prostatic Heart Valve</li> <li><input type="checkbox"/> Irregular Heartbeat</li> <li><input type="checkbox"/> High Cholesterol</li> </ul> <p><input type="checkbox"/> <b>Endocrine Disease:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Hyperthyroid</li> <li><input type="checkbox"/> Hypothyroid</li> </ul> <p><input type="checkbox"/> <b>Neurological Disease:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Stroke/Aneurysm</li> <li><input type="checkbox"/> Seizure/Epilepsy</li> <li><input type="checkbox"/> Multiple Sclerosis (MS)</li> <li><input type="checkbox"/> Alzheimer's</li> <li><input type="checkbox"/> Fainting</li> </ul> <p><input type="checkbox"/> <b>Liver Disease:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hepatitis: Type <u>                    </u></li> <li><input type="checkbox"/> Jaundice</li> </ul> <p><input type="checkbox"/> <b>Lung Disease:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> COPD</li> <li><input type="checkbox"/> Tuberculosis</li> </ul> <p><input type="checkbox"/> <b>Kidney Disease:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Poorly functioning kidneys</li> <li><input type="checkbox"/> Dialysis: Type <u>                    </u></li> </ul> <p><input type="checkbox"/> <b>FOR FEMALE PATIENTS ONLY!!</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Polycystic Ovary Disease</li> <li><input type="checkbox"/> Infertility</li> <li><input type="checkbox"/> Nursing? Yes / No</li> <li><input type="checkbox"/> Pregnant? Yes / No / Not sure - If yes, when's the due date? <u>                    </u></li> <li><input type="checkbox"/> Are you <u>trying</u> to get pregnant? Yes / No</li> <li><input type="checkbox"/> Last menstrual cycle: <u>                    </u></li> </ul> <p><input type="checkbox"/> <b>Other/Not Listed:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Transplant? Yes / No             <ul style="list-style-type: none"> <li><input type="checkbox"/> What Type? <u>                    </u></li> </ul> </li> <li><input type="checkbox"/> <u>                    </u></li> <li><input type="checkbox"/> <u>                    </u></li> <li><input type="checkbox"/> <u>                    </u></li> </ul>
<p><i>Additional Information Dr. Campbell may need to be aware of:</i></p>	

**Previous Injuries:**

Have you ever had any 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 unknown 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. (excluding any contractual agreements for ALIGNED CHIROPRACTIC PLLC and DR FELICIA CAMPBELL DC). **Payment in full (co-payments and deductibles included) is required at the time of service.**

- *We offer a group discount of 50% on services for patients 17 and under without or forgoing insurance OR for patients with financial hardship. 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.

**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: \_\_\_\_\_

### 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. \*\*\*\*\* [redacted] \*\*\*\*\* (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 healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- 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 signed by:

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_



Patient Responsibility Form

Please initial next to each statement and sign at the bottom.

- I understand that I am financially responsible for any medical bill(s) that are accrued while receiving treatment at **Aligned Chiropractic PLLC**, in the case that my bill(s) are not paid for. \_\_\_\_\_
- I understand that I am financially responsible for my health insurance deductible, co-insurance, co-payment, or non-covered service. \_\_\_\_\_
- In the event that my health plan determines a service to be “not payable” or “non-covered”, I will be responsible for the complete charge and agree to pay the costs of all services provided. \_\_\_\_\_
- I understand that payments are due at the time at service unless otherwise discussed with **Dr. Felicia Campbell, D.C.** \_\_\_\_\_
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service. \_\_\_\_\_

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Signature of Patient, Authorized Representative or Responsible Party

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Date

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Print Name of Patient, Authorized Representative or Responsible Party

# ALIGNED CHIROPRACTIC

## Understanding your Insurance Coverage

Acute Care (**covered by insurance**) vs Maintenance Care (**not covered by insurance**)

- **What is acute care?**

Acute care is considered short-term care, possibly a few weeks or months, to take care of a particular injury. It is meant to alleviate immediate pain or symptoms. These symptoms can originate from a variety of sources and can be caused because of an underlying spinal dysfunction or accident/trauma.

- **What is maintenance or wellness care?**

Maintenance or wellness care is focused on the proper function and movement of the body and spinal joints in order to boost the overall health and healing of the body. It is also meant to help maintain or keep your current condition(s) stabilized.

- **Is there a certain amount of treatment that is covered?**

For most plans, your insurance will provide you a certain number of visits that you are allowed to use during a calendar year period. However, keep in mind that the amount or length of treatment that is covered by insurance is not necessarily defined by the number of visits or types of treatment. Rather, the treatment is covered as long as it demonstrates significant, lasting, or progressive improvement to your condition.



- **When is chiropractic care covered by my health insurance plan?**

Chiropractic care is covered by your health insurance plan if it is for acute (short term) care, such as a recent injury or for a condition where treatment offers lasting benefit or curative value.

- **Is there a certain amount of treatment that is covered?**

For most plans, the amount or length of treatment that is covered by insurance is not necessarily defined by the number of visits or types of treatment. Rather, the treatment is covered as long as it demonstrates significant, lasting, or progressive improvement to your condition.

- **When is chiropractic care NOT covered by my health insurance plan?**

Chiropractic care is **NOT** covered by your health insurance plan when you reach a point in treatment where chronic symptoms remain stable or where you no longer show progress in reducing these chronic symptoms through chiropractic care. At this point, you have reached what is called "maintenance" care.

- **How will I know if I have reached the end of covered care?**

We want to be transparent and upfront about your care. Dr. Felicia will let you know when you have reached a point of "maintenance" care and will discuss further care options.

- **What happens when I am determined to have reached the end of covered treatment but still want to have regular chiropractic adjustments?**

You may continue maintenance treatment, but you must pay for it completely out-of-pocket. If you choose to receive chiropractic care beyond acute care, it is a cash service where you would be responsible for payment.

- **How will I know the cost to me of the maintenance care?**

Prior to receiving maintenance care, we will discuss the cost with you so that you are fully aware, in advance, of the cost for this elected service.

- **Is it possible to move from maintenance care back to chiropractic care covered by my insurance plan?**

If you sustain a future incident or injury, your chiropractic care would again meet the criteria for acute care and would be covered by your health plan, until that condition has reached a plateau level and does not provide any more lasting, curative value.

- **Who should I contact with questions?**

Please contact our office for questions regarding your benefit coverage and we would be happy to discuss that with you.

**I acknowledge that I have read and reviewed this form in its entirety, and understand that I have the right to ask any questions concerning my insurance benefits.**

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature for Minor Patient: \_\_\_\_\_ Date: \_\_\_\_\_