

Patient Records of Disclosure

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's office instead of the individuals home.

I wish to be contacted in the following manner (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Home telephone
PHONE #: _____ | <input type="checkbox"/> Work Telephone
WORK #: _____ |
| <input type="checkbox"/> OK to leave message with information | <input type="checkbox"/> OK to leave message with information |
| <input type="checkbox"/> Leave message with call back number only | <input type="checkbox"/> Leave message with call back number only |
|
 | |
| <input type="checkbox"/> Written Communication | |
| <input type="checkbox"/> OK to mail to my home | ADDRESS : _____ |
| <input type="checkbox"/> OK to mail to my work | ADDRESS : _____ |
| <input type="checkbox"/> OK to fax to this number | FAX #: _____ |

Patient Signature

Date

Print Name

Birthdate

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax #	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this if the disclosure is authorized (2) Type Key: T=Treatment records: P=Payment Information: O=Healthcare Operations
 (3) Enter how the disclosure was made: F=Fax: P=Phone: E=Email: M=Mail: O=Other

Patient Name: _____ DOB: _____ ACCT: _____

CONFIDENTIAL HISTORY FORM

WENDELL FAMILY CHIROPRACTIC AND PERFORMANCE CENTER

Date: _____ E-Mail: _____ Cell Phone: (____) _____

Name (Mr. / Mrs. / Miss / Ms.): _____ Home Phone: (____) _____

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

Date of Birth: ____ / ____ / ____ Age: _____ SSN: _____ DL: _____ State: _____

Occupation: _____ Employer: _____ Work Phone: (____) _____

Occupation Address: _____
Street City State Zip

[] Single [] Married [] Other Spouses Name: _____ DOB: ____ / ____ / ____

Nearest Relative Not Living With You: _____ Relationship: _____

Phone: (____) _____ Street Address: _____ City: _____

State: _____ Zip: _____

Who (or what source) referred you? _____

Previous Chiropractic Care: [] YES [] NO Doctor's Name: _____

Name of Health Insurance Company: _____

Insurance Holder's Name: _____ Date of Birth: ____ / ____ / ____ SSN: _____

Insured's Employer: _____ Your Relationship: [] Self [] Spouse [] Mother [] Father

CHECK FOR SYMPTOMS YOU ARE HAVING

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Left Shoulder Pain | <input type="checkbox"/> Right Shoulder Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Left Shoulder Blade Pain | <input type="checkbox"/> Right Shoulder Blade Pain | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Left Arm Pain | <input type="checkbox"/> Right Arm Pain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Left Hand / Wrist / Finger Pain | <input type="checkbox"/> Right Hand / Wrist / Finger Pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Left Hip Pain | <input type="checkbox"/> Right Hip Pain | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Left Leg Pain | <input type="checkbox"/> Right Leg Pain | |
| | <input type="checkbox"/> Left Knee Pain | <input type="checkbox"/> Right Knee Pain | |
| | <input type="checkbox"/> Left Foot Pain | <input type="checkbox"/> Right Foot Pain | |

Other: _____

Have you seen a doctor for these symptoms: YES / NO

List Medications, if any: _____

Is this complaint due to a work related or auto accident: YES / NO

Any time lost from work due to this illness or accident: YES / NO From: _____ To: _____

IT IS USUAL AND CUSTOMARY TO PAY FOR SERVICES AS RENDERED UNLESS OTHERWISE ARRANGED:

*I do hereby authorize Wendell Family Chiropractic, (Dr. Mark T Vardy) to furnish my Insurance Co. with full report of physical examination, diagnosis, treatment, prognosis, etc. of myself in regard to my injury if requested by them. I hereby authorize and direct payment directly to said doctor such sums as may be due owing him for chiropractic service rendered me. **I UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO SAID DOCTOR FOR ALL MEDICAL BILLS SUBMITTED BY HIM FOR SERVICE RENDERED ME.** This agreement is made solely for said doctors' additional protection and in consideration of his awaiting payment.*

I have read and agree to be bound by the terms of this assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting the doctors interest, he will not await payment but may declare the entire balance due and payable: these assigned proceeds shall not exceed amounts due and payable to doctor for services rendered.

Patient Signature: _____ Date: _____

If Minor, Parent/Guardian Signature of Consent: _____ Date: _____

Office Witness: _____ Date: _____ ACCT #: _____

Below are lists of diseases which may seem unrelated to the purpose of your appointment, However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following diseases you have had throughout your lifetime:

- YES NO Pneumonia
- YES NO Rheumatic Fever
- YES NO Polio
- YES NO Tuberculosis
- YES NO Whooping Cough
- YES NO Anemia
- YES NO Measles
- YES NO Mumps
- YES NO Small Pox
- YES NO Chicken Pox
- YES NO Diabetes
- YES NO Cancer
- YES NO Heart Disease
- YES NO Thyroid
- YES NO Influenza
- YES NO Pleurisy
- YES NO Arthritis
- YES NO Epilepsy
- YES NO Mental Disorders
- YES NO Lumbago
- YES NO Eczema

INTAKE

- YES NO Coffee
- YES NO Tea
- YES NO Alcohol
- YES NO Cigarettes
- YES NO White Sugar

FAMILY HISTORY

The following members have a same or similar problem(s) as I do:

- YES NO Mother
- YES NO Father
- YES NO Brother
- YES NO Sister
- YES NO Spouse
- YES NO Child

MISC.

- YES NO Have you been tested HIV Positive?

Check any of the following problems that you have had within the past 6-month:

MUSCULO-SKELETAL

- YES NO Low Back Pain
- YES NO Pain Between Shoulders
- YES NO Neck Pain
- YES NO Arm Pain
- YES NO Joint Pain / Stiffness
- YES NO Walking Problems
- YES NO Difficulty Chewing / Clicking Jaw
- YES NO General Stiffness

NERVOUS SYSTEM

- YES NO Nervous
- YES NO Numbness
- YES NO Paralysis
- YES NO Dizziness
- YES NO Forgetfulness
- YES NO Confusion/ Depression
- YES NO Fainting
- YES NO Convulsions
- YES NO Cold Tingling Extremities
- YES NO Stress

GENERAL

- YES NO Fatigue
- YES NO Allergies
- YES NO Loss of Sleep
- YES NO Fever
- YES NO Headaches

GASTRO-INTESTINAL

- YES NO Poor / Excessive Appetite
- YES NO Excessive Thirst
- YES NO Frequent Nausea
- YES NO Vomiting
- YES NO Diarrhea
- YES NO Constipation
- YES NO Hemorrhoids
- YES NO Liver Problems
- YES NO Gall Bladder Problems
- YES NO Weight Trouble
- YES NO Abdominal Cramps
- YES NO Gas/Bloating after Meals
- YES NO Heartburn
- YES NO Black/Bloody Stool
- YES NO Colitis

GENITO-URINARY

- YES NO Bladder Trouble
- YES NO Painful/Excessive Urination
- YES NO Discolored Urine

C-V-R

- YES NO Chest Pain
- YES NO Short Breath
- YES NO Blood Pressure Problems
- YES NO Irregular Heartbeat
- YES NO Heart Problems
- YES NO Lung Problems
- YES NO Congestion
- YES NO Varicose Veins
- YES NO Ankle Swelling
- YES NO Stroke

EENT

- YES NO Vision Problems
- YES NO Dental Problems
- YES NO Sore Throat
- YES NO Ear Aches
- YES NO Hearing Difficulty
- YES NO Stuffed Nose

MALE / FEMALE

- YES NO Menstrual Irregularity
- YES NO Menstrual Cramps
- YES NO Vaginal Pain / Infection
- YES NO Breast Pain / Lumps
- YES NO Prostate / Sexual Dysfunction
- YES NO **Other Problems**

FEMALES ONLY

- YES NO Are You Pregnant? When was your last period?

DO NOT WRITE BELOW THIS LINE

Chiropractic Analysis: _____

Diagnosis: _____

Patient Accepted: YES NO Referred

Doctor's Signature

Date

Patient Name: _____ DOB: _____ ACCT. #: _____

PATIENT CONSENT FORM

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician (s).

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Wendell Family Chiropractic to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 919-366-3111. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual period _____.

Patient's Signature: _____ Date: _____ Front Desk _____ Date: _____

Patient Name: _____ DOB: _____ ACCT: _____

Pain Diagram

Patient Name _____

Date _____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the types of pain:

D= Dull

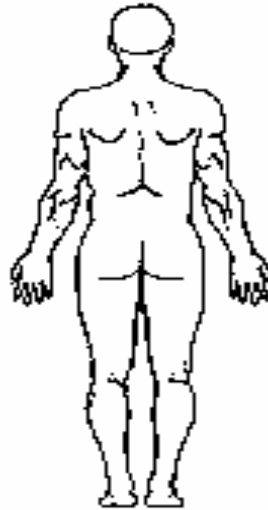
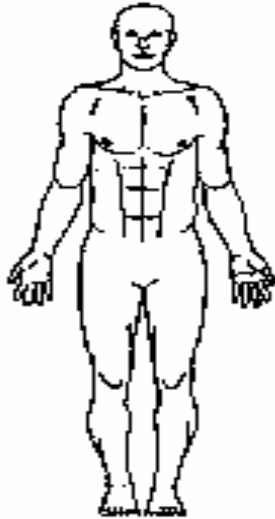
B= Burning

N= Numb

S= Stabbing/ Cutting

T= Tingling (Pins & Needles)

C= Cramping



Indicate the severity of your symptoms by marking an "X" on the lines below:

How bad are your symptoms now?

None Severe

How bad have they been in the past?

None Severe

Patient Name _____ DOB _____ ACCT# _____

METHOD OF PAYMENT CHOICE

PLEASE CHECK AND SIGN THE METHOD YOU PREFER TO USE TO PAY FOR SERVICES RENDERED FROM **WENDELL FAMILY CHIROPRACTIC CLINIC**.

- () NON-INSURANCE () HEALTH INSURANCE () MEDICAL PAY / LIABILITY INS. / ATTORNEY
- () I wish all my Chiropractic Records, Including my Personal History, Findings from any Examination, X-Rays or Laboratory procedures to be held in strict secret confidence and not be given to anyone without written consent. () I hereby authorize Wendell Family Chiropractic Clinic to release information to my Attorney, Insurance Company or Related persons who request such information.

Signature Date

- Non-payment on an account for more than 30 days will result in a 1.5% late fee per month.

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care

- 1) **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed \$200 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.
- 2) **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed \$200 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We gladly accept assignment for secondary insurance.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

If you discontinue care for any reason, all balances will become immediately due and payable in full by you and any unpaid insurance balances that result in a patient balance, will then be your responsibility also.

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____ Front Desk _____ Date: _____

For your convenience you may retain your credit card number on file with us.

Card #: _____ Expiration Date: _____

Name as appears on card: _____

Patient Name: _____ DOB: _____ ACCT: _____