Patient Health History

Today's Date [/   /   ] **Signature of Patient** ______________________

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name______________________**Nick Name**______________________

Last Name______________________**Middle Name**______________**Suffix** ________

Address 1 ____

Address 2 ____

City______________________**State**__________**Zip Code** __________

Primary Phone__________________**Secondary Phone** __________________

Mobile Phone ____

Home email______________________**Work Email** ______________________

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth [/   /   ] **Age**________**Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** __________________

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other__________	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Continued ...

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Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: ______________________________
Answers must be at least 6 characters.

Are you pregnant? ❑ Yes ❑ No ❑ Don't know

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest — *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here ❑

	Start Date		Start Date
1)		5)	
2)		6)	
3)		7)	
4)		8)	

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1)______________________ 3)______________________

2)______________________ 4)______________________

Briefly list your main health problems: ______________________________

____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: ______________

____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ______________________________

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height:______inches **Weight:**__________pounds **BP:**_______/ ________

Name: ______________________________ **DOB:** ________ **Date of Visit:** _____________

PAIN DESCRIPTORS

Place an **"X"** on the drawing to the right on the areas of pain and a **LETTER** describing the pain.

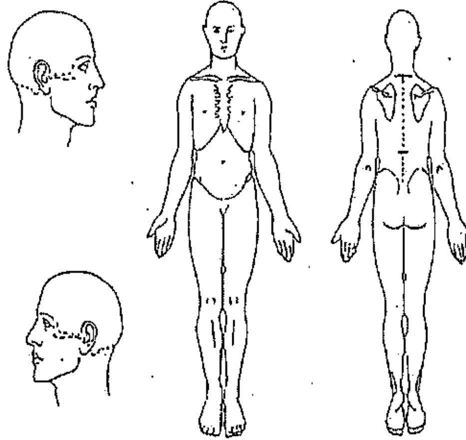
A = **ACHE**

B = **BURNING**

S = **STABBING**

N = **NUMBNESS**

P = **PINS & NEEDLES**



NOTES: (DOCTOR USE ONLY)

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TELL US A LITTLE MORE ABOUT YOUR PAIN

Body Part	Pain Scale	Circle the Frequency Pain Affects You
HEAD/NECK	0 1 2 3 4 5 6 7 8 9 10 NONE LITTLE MEDIUM SEVERE	25-50% 50-75% 75-100%
UPPER BACK	0 1 2 3 4 5 6 7 8 9 10 NONE LITTLE MEDIUM SEVERE	25-50% 50-75% 75-100%
LOWER BACK	0 1 2 3 4 5 6 7 8 9 10 NONE LITTLE MEDIUM SEVERE	25-50% 50-75% 75-100%

SURGERIES/ HOSPITLIZATIONS

Date	Surgery	Reason	Result

OTHER CONDITIONS: (CANCER, HEART DISEASE, ARTHRITIS, ECT.)

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________

Ford Chiropractic, Inc.
1304 North Main Street
LaFayette, GA 30728

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Ford Chiropractic, we may use or disclose personal and health related information about you in the following ways:

1. Your personal health information, including your clinical records, may be disclosed to another health care provider of hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
2. Your medical records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are responsible for the payment of your services.
3. Your name, address, phone number, and your medical records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
4. We will use your health information to provide you with health care treatment and to coordinate or manage services with other health care providers, including third parties. We may disclose your health information to family members or friends, guardians or personal representatives who are involved with your medical care.
5. We may disclose your health information in response to a court or administrative order, a valid subpoena, discovery request, civil/criminal proceedings or other lawful process.
6. We may release your health information for workers' compensation benefits or to similar programs that provide benefits for work-related injuries or illness.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barrier to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home address or if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

Acknowledgements

Chiropractic care: ☐ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Privacy Verification: ☐ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Permission to contact: ☐ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Payment Verification: ☐ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

X-ray Verification: *(females only)* ☐ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant or I understand the risks.

Date of last menstrual period:

General Verification: ☐ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature: ______________________________ Date: ______________________

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Ford Chiropractic, Inc.

1304 North Main Street - LaFayette, GA 30728

Welcome to our office! We are happy you have chosen Ford Chiropractic for your healthcare needs. Your health is your greatest asset and therefore one of the best things you can invest in financially.

YOUR FIRST VISIT...

All services rendered during the first visit MUST be paid for at that time whether you have insurance coverage, Medicare coverage, or no coverage at all. You may pay by cash, check, or credit card. If your insurance has not been verified by our office, you will be on a "cash" or "non-insurance" basis until coverage has been confirmed. If this results in an overpayment, we will credit your account or reimburse you when our office receives final payment from the carrier and care has been completed.

MANAGED CARE POLICIES (PPO, HMO, etc.) AND MEDICAL INSURANCE...

If you have a managed care policy or medical insurance that Dr. Ford is contracted with as a participating provider, you are responsible for all co-payments and non-covered services. Patients seeing the doctor for more than one visit per week are encouraged to make payment for all co-pays and non-covered services at the beginning of the week. This coverage is usually subject to the deductible and/or percentage co-pay (see below).

DEDUCTIBLE POLICIES...

We gladly accept insurance assignment if the insurance company, 1) Verifies the deductible has been met, 2) Provides details of the available coverage, and 3) Agrees to make payment directly to our office. Please understand that insurance is an agreement between you and the insurance company. The agreement is not between the insurance company and Ford Chiropractic unless we are in contract with your insurance company. In every case the patient or their guardian is ultimately responsible for all fees with the exception of contracted deductions. If your insurance company gives us the wrong information or if your insurance company just fails to pay for any reason, you are ultimately responsible.

TIME OF SERVICE PAYMENT (CASH)...

If you are not using insurance and choose to pay out of pocket, all charges need to be paid at the time of service. Some services are discounted for "cash" paying patients.

MEDICARE...

Ford Chiropractic does NOT accept assignment with Medicare; however, we do file the charges to Medicare for you. Medicare does NOT cover Exam, X-Rays, or Therapies. Medicare patients must pay for all services rendered at the time of service. If Medicare covers the service, a check will be sent directly to the patient.

PAYMENT PLANS…

Minimum payment required for our payment plan is $40 a week or $160 per month. Payments must continue until the entire balance is paid in full (even if you are no longer under active care). If you choose to participate in a payment plan, we will need to obtain a credit card number or blank check to keep on file. These will only be used if you fail to make your regularly scheduled payment.

CARE CREDIT…

Ford Chiropractic offers an alternative to the "in-house" payment plan through Care Credit (funded by GE Money Bank). Care Credit is a financial service that can be used at all participating physicians' offices and most of the time, you can pay your balance with 0% interest. Please ask about applying for Care Credit if you are interested and we will provide you with an information packet.

PAST DUE ACCOUNTS…

Delinquent accounts will be sent to a collection agency that reports to major credit bureaus after we have exhausted all attempts to collect the balance with all applicable fees added to the account balance.

AFTER HOURS/EMERGENCIES…

Emergency care after hours, on weekends or holidays is available. Please be aware that after hours calls are subject to additional charges and may not be covered by your insurance company. These charges are in addition to the services rendered and you, the patient will be solely responsible for your payment.

Description of Service	Insurance	Non-Insurance	Medicare
Exam	$30-70.00	$60.00	N/A
X-Rays (per region: cervical, thoracic, lumbar, or extremities	$20-60.00	$40.00	N/A
Adjustment	$35.00	$35.00	$40.00
Therapy (E-stim, Ultrasound, Hydrotherapy, Spinalator)	$15-35.00	$15.00	N/A
Spinal Decompression	$15-25.00	$25.00	N/A
Trigger Point Therapy	$15-35.00	$15-25.00	N/A

Check Acceptance Policy

By using a check for payment, you agree to the following terms: In the event your check is dishonored or returned for any reason, you authorize us to electronically (or by paper draft) re-present the check to your bank account for collection of the amount, plus any applicable fees as permitted by law.

I have read, understand, and agree to the above stated policies of Ford Chiropractic, Inc.

Patient Signature Date

We are required by state and federal law to maintain the privacy of your patient ıne and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you should direct your complaint to: Dr. Aaron Ford.

This notice is effective April 14, 2003. This notice and any alterations or amendments made hereto will expire ten years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

I hereby authorize the following: (Please Initial All That Apply)

_____ Release of medical information to other medical providers, by phone, in person, or by mail as necessary for continued care process.

_____ Release of medical information to other medical providers, as necessary, VIA FAX, as requested by them.

_____ Release of medical information, as necessary, VIA FAX, INTEROFFICE COURIER, IN PERSON, OR BY MAIL for claims/billing processes.

_____ Voicemail messages on my personal phone/answering on my personal phone/ answering macine regarding appointments/callbacks, etc.

_____ I authorize, as necessary, test results, appointments, etc. To be given to ____________ who is my ______________ (relationship to person named) in my absence.

____

Patient Name (Printed)   Patient Signature   Date

If you are a minor, or if you are being represented by another party:

____

Personal Representative (Printed)   Personal Representative Signature   Date

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits other wise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____

Patient Signature (or parent/guardian if minor)   Date

PATIENT ELECTION TO SELF-PAY FOR SERVICES

I,______________________________ , the undersigned patient, acknowledge that I understand and agree that:

1. **Ford Chiropractic** is a participating provider with ______________________.

2. I am covered by one of the Company health insurance plans.

3. The health plan under which I am covered includes benefits for some or all of the services provided by Clinic.

4. Despite the above, I do not wish Clinic to submit a claim to Company for services provided to me by Clinic which exceed my visit maximum limit or are uncovered services.

5. Until such time as I may otherwise advise Clinic in writing, I elect to pay for the above specified services I receive from Clinic at their time of service discounted rates.

6. By election to self-pay for services, any payments I make to Clinic will not be credited toward satisfying any deductible I may be subject to under my health insurance plan with Company unless otherwise permitted under the terms of my health plan.

7. I have read this Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about the form. Any questions I may have had about this form have been answered to my satisfaction.

8. I have freely chosen to self-pay for services after having asked Clinic about payment options and having carefully considered those options.

Date:______________ Patient: ______________________________

Signature of patient or responsible party if patient is a minor or is otherwise unable to sign for him/herself

____

Printed Name of Patient or Responsible Party and Capacity of Responsible Party (e.g. parent, guardian, etc.)