AXIS REHAB & CHIROPRACTIC

CONFIDENTIAL PATIENT HEALTH HISTORY

CURRENT HEALTH CONDITION

Primary Complaint _____

How and When Did This Condition Develop? _____

This Condition Is: Sports Injury_____ Job Related____ Auto Accident____ Overexertion____ Fall____ Other

Describe Your Pain/Symptoms: Dull_____ Sharp____ Stabbing____ Throbbing____ Numbness____ Other___

Your Pain/Symptoms Are: Intermittent_____ Occasional_____ Frequent_____ Constant_____

What Aggravates the Problem: Coughing_____ Sneezing_____ Lifting_____ Bending_____ Sitting __

Running_____ Standing_____ Driving_____ Walking_____ Sleeping_____ Other___

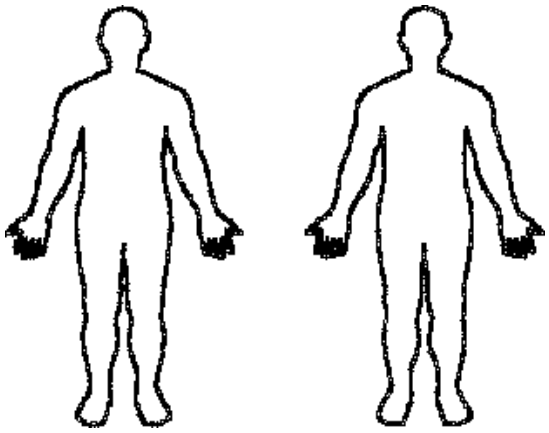
What Relieves the Problem: Rest_____ Exercise_____ Sitting_____ Standing_____ Lying_____ Other_____

Are You Currently On Any Medications? _____

Has This Condition Occurred Before? _____

Have You Ever Had Medical Treatment For This Condition? _____

Mark an X on the Diagram Where You Are Having Pain or Other Symptoms.



Front **Back**

Pain Scale – Please Circle Number

0 1 2 3 4 5 6 7 8 9 10

Low **Moderate** **Increase** **High**

PAST HEALTH HISTORY

General Health: Excellent_____ Good_____ Fair_____ Poor (Explain) _____

List Any Major Surgery/Operations/Hospitalization_____

Major Accidents/Falls_____ Fractures/Broken Bones_____

Alcohol_____Tobacco_____Allergies_____

Vitamins/Drugs/Medication (Past Or Current)_____

Exercise: Amount_____ Type_____ Difficulties_____

Diet: Excellent_____ Good_____ Fair_____ Poor (Explain) _____

Family History_____

Females: Pregnant? _____ Nursing Child? _____

Additional History & Doctor Notes_____

Patient Signature_____ Date_____

Doctor Signature_____ Date_____

AXIS REHAB & CHIROPRACTIC

YOUR PRIVACY - PATIENT HEALTH INFORMATION

This notice describes how we may use and disclose medical information about you. Please read it carefully before signing.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Your Right to Privacy

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use of disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This authorization will expire seven years after the date on which you last received services from us.

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms.

Name_____ Date_____

Signature_____

AXIS REHAB & CHIROPRACTIC

Confidential Patient Information

Patient Name_____ Date of Birth_____ Sex___

Address _____Apt #_____

City_____ State_____ Zip_____ SS#_____

Home Phone_____ Cell Phone_____

Work Phone_____ Email _____

Marital Status _____ Employer _____ Occupation _____

Emergency Contact _____ Phone _____

How did you hear about us? _____

Do you have Insurance? **YES** or **NO** (If YES, please complete below)

Insurance Registration and Verification

Insured Name_____ Date of Birth_____ Sex____

Address (if different)_____ City_____ State_____

Zip_____ SS#_____ Email _____

Home Phone_____ Cell _____

Employer_____ Work Phone_____

Insurance Company_____ Phone _____

Member ID#_____ Group ID #_____

Relationship to Insured: Self _____ Spouse_____ Child_____

Patient Signature_____ Date_____

AXIS REHAB & CHIROPRACTIC

INFORMED CONSENT TO CHIROPRACTIC & REHAB TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-rays and physical rehabilitation techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

Most insurance policies cover chiropractic care, but this office makes no representation that yours does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient be billed and, be personally responsible for the payment of your deductibles, as well as any unpaid bills in this office that were not paid by your insurance company. We will do our best to verify your insurance coverage, and will bill your insurance company in a timely manner. Depending on your insurance company, Axis Rehab may be an out of network provider.

ASSIGNMENT OF BENEFITS

I irrevocably assign to Axis Rehab all my right and benefits under my insurance contracts for payment for services rendered to me by Axis Rehab. I irrevocably authorize all information regarding my benefits under any insurance policy relating to claims by Axis Rehab to be released to Axis Rehab. I irrevocably authorize Axis Rehab to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to Axis Rehab. I irrevocably authorize Axis Rehab to act in my behalf and report any suspected violations of proper claim practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

PATIENT REIMBURSEMENT FROM INSURANCE COMPANY

In the event that my insurance company sends payments directly to me for services rendered by Axis Rehab, I agree to immediately forward the payments and the EXPLANATION OF BENEFITS (EOB) to Axis Rehab.

I authorize the release of any medical or any other information necessary to process any claims for services rendered. I authorize the payment of benefits for services rendered to Axis Rehab. I authorize a copy of this consent and authorization to be used in all of my insurance submissions. I authorize Axis Rehab to endorse any checks made payable to me and/or Axis Rehab for services rendered.

APPOINTMENT CANCELLATION POLICY

If this office does not receive notice of an appointment change or cancellation twenty-four (24) hours before the scheduled appointment time, or if the patient does not show up for a scheduled appointment, there will be a **$50.00 charge**.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_____

Patient Name (Please Print)

_____ _____

Signature of Patient **Date**