Hun Chiropractic
1 Creekview Ct, Suite B
Greenville, SC 29615
P: 864-990-4752 F: 864-288-8593

Personal Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Date of Birth: _____ Age: _____ Social Security #: _____-_____-_____ Gender: □ Male □ Female

E-mail Address: _____ Occupation: _____

Employer/School: _____ Phone: _____-_____-_____

Spouse's Name: _____ Date of Birth: _____ Social Security #: _____-_____-_____

Spouse's Employer: _____ Phone: _____-_____-_____

In case of emergency, contact: _____ Relationship: _____

Insurance Information

Who is responsible for this account? _____ Relationship: _____

Insurance Company: _____ Group #: _____ ID #: _____

Is Patient covered by additional insurance? □ No □ Yes

Subscriber's Name: _____ Date of Birth: _____ Social Security #: _____-_____-_____

Relationship to Patient: _____ Insurance Company: _____ Group #: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ (insurance co) and assign directly to Dr. Nick Hun all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctors may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature: _____ Date: _____

Print Name: _____ Date: _____

Relationship to Patient: _____

Allergies

□ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs □ Latex □ Molds □ Penicillin □ Ragweed/Pollen

□ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye □ Other: _____

Surgeries

□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □ Wrist □ Other:_____

Past Medical History

□ Ankle Pain □ Arm Pain □ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer □ Chest Pain □ Depression

□ Diabetes □ Dizziness □ Elbow Pain □ Epilepsy □ Eye/Vision Problems □ Fainting □ Fatigue □ Foot Pain

□ Genetic Spinal Condition □ Hand Pain □ Headaches □ Hearing Problems □ Hepatitis □ High Blood Pressure

□ Hip Pain □ HIV □ Jaw Pain □ Joint Stiffness □ Knee Pain □ Leg Pain □ Menstrual Problems □ Mid-Back Pain

□ Minor Heart Problem □ Multiple Sclerosis □ Neck Pain □ Neurological Problems □ Pacemaker □ Parkinson's

□ Polio □ Prostate Problems □ Shoulder Pain □ Significant Weight Change □ Spinal Cord Injury □ Sprain/Strain

□ Stroke/Hear Attack □ Other:_____

Medications

□ Anxiety □ Muscle Relaxers □ Pain Killers □ Insulin □ Birth Control □ Cardiovascular □ Allergy □ Seizure

□ Other:_____

Do you take Vitamins/Supplements? □ No □ Yes

Family History

□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression □ Diabetes □ Epilepsy □ Genetic Spinal Condition

□ High Blood Pressure □ Heart Problems □ Multiple Sclerosis □ Neurological Problems □ Parkinson's □ Polio

□ Prostate Problems □ Stroke/Heart Attack □ Other:_____

Have you had any auto or other accidents? □ No □ Yes

Describe:_____

Have you ever cracked or broken a rib? □ No □ Yes - when? _____ how? _____

Do you have pain when you cough, sneeze, or bear down to go to the bathroom? □ No □ Yes

Date of last physical examination: _____

Do you smoke? □ No □ Yes

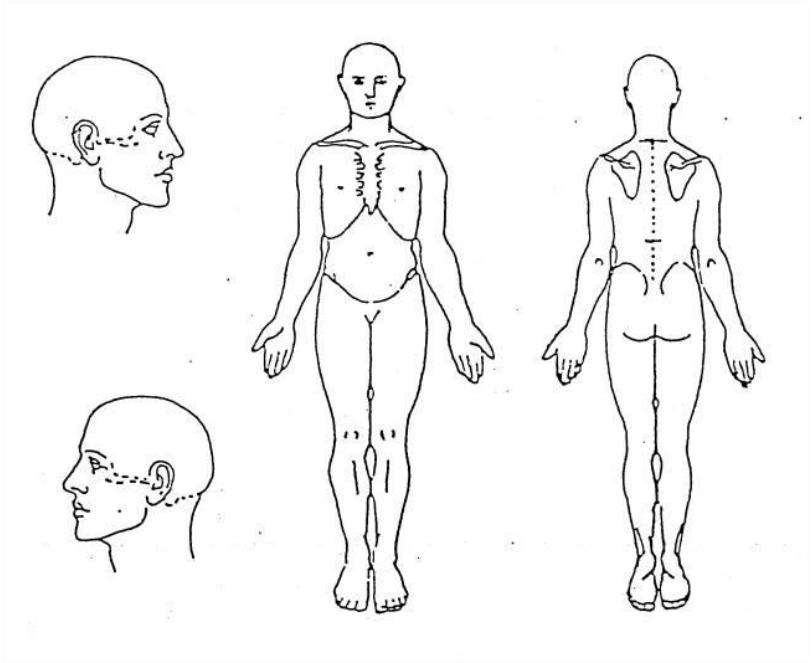
Do you drink alcohol? □ No □ Yes – how many per day? _____

Do you drink caffeine? □ No □ Yes – how many per day? _____

Do you exercise? □ No □ Yes – what forms and how often? _____

Patient Condition

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW
(mark ALL areas with XXXXXXX)



Main reason for consulting our office:

- □ Become pain free
- □ Explanation of my condition
- □ Learn how to care for my condition
- □ Reduce symptoms
- □ Resume normal activity level

What is your MAJOR complaint? _____ Date problem began? _____

How did this problem begin? (falling, lifting, etc.)?_____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? □ YES □ NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0 = no pain, 10 = excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0 = no effect, 10 = no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc.)? _____

What makes your pain better (ice, heat, massage, etc.)? _____

Are there any other Health Concerns that you would like to talk to us about? _____

Have you ever been to a Chiropractor before? □ No □ Yes – How long ago? _____

Whom may we thank for referring you? How did you find out about us? _____

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INSURANCE FINANCIAL POLICY

It is our office policy to collect for services as they are rendered. If charges for services are covered by insurance, we will submit a claim for benefits upon receipt of necessary information from you. After insurance has been verified and deductible has been met, you can then pay your percentage or co-pay.

Assignment, Authorization, & Policy Statement:

I hereby assign benefits to Hun Chiropractic and I declare that I am eligible to receive care rendered by Hun Chiropractic.

I authorize the office to release any information to any insurance company, adjuster, or attorney that will assist in the payment of claims.

- I fully understand and agree that insurance policies are a contract between an insurance company and myself – Not between an insurance company and Hun Chiropractic. Therefore I realize that I am fully responsible for any expenses not paid for by my insurance company. I also agree that should my insurance company not pay within 6 weeks of services rendered, I will pay my account in full.
- By signing this document, I am taking full responsibility for payment of the services I receive at Hun Chiropractic, Inc.
- Furthermore, I agree that if I do not abide by the financial policies stated above, my account will be turned over to your collections agency with a 35% collection fee to be collected at my expense.

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All information that I have provided Hun Chiropractic including all information provided on my Chiropractic Registration and History form as well as any additional insurance information is correct. I understand that you will retain this Chiropractic Registration and History Form in my file.

Patient Signature: _____ Date: _____

Employee Witness: _____

If you have any questions regarding our policies, please let us know.

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CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Privacy Pledge To You:

We are very concerned with protecting your privacy. While the Law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances where we may have to use or disclose your health information:

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

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have a right to review that notice before you sign this consent for (164.520). We reserve the right to change our privacy practice as described in that notice. If any changes are made, you will be notified in writing by our office. Please feel free to call us at anytime for a copy of our privacy notices.

Your Right To Limit Uses Or Disclosures:

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

Your Right To Revoke Authorization:

You may revoke your consent to us at any time; but it must be done in writing. We will not be able to honor your revocation request if we have already released your health information prior to receiving your request to revoke 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.

APPOINTMENT REMINDER AND HEALTH CARE INFORMATION AUTHORIZATION

Your Chiropractor and members of our staff at Hun Chiropractic need to use your name, address, phone number, and your records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may interest you. If this contact is made by phone and you are not 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 information is released to or you may revoke your authorization to us at any time. However, your revocation must be done in writing and mailed to our office address. We will not be able to honor any revocation request if we have already released your health information prior to our office receiving your request to revoke authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to detest a claim.

Information we use or disclose based on the authorization you're giving 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 this authorization, it will not affect the treatment we provide to you or the method we use to obtain reimbursement for your bare.

You may inspect or copy the information we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time. (164.524)

- I have read your consent policy and agree to its terms. I am also acknowledging that I have received or been offered a copy of this notice.
- This notice is effective as of the date listed below. This authorization will expire seven years after the date of which you last receive services from us. I authorize you to use or disclose my health information in the manner described above.

Patient Signature:_____ Employee Witness: _____ *(Or Personal Representative- also please describe how personal representative acts as authority for patient)