# Whitney Chiropractic

WHITNEY CENTER

Chiropractic, Sports & Rehabilitation

At **Whitney Chiropractic** we are committed to providing you with a personalized chiropractic plan to optimize your health. In order to help us do this, please tell us a little about your goals for treatment.

**Confidential Information**

Date:_____

Name:_____

Social Security Number:_____-_____-_____

Address:_____

City:_____ State:_____ Zip:_____

E-Mail:_____

Cell phone:_____

Home phone:_____

Work phone:_____

Date of Birth:_____/_____/_____

Age:_____years

Marital status Please circle: Single Married Divorced Widowed

Gender Please circle: Male Female

If female, are you or could you be pregnant? Please circle: No Yes

Occupation:_____ Name of Employer:_____

Name of insurance company:_____

Name of Holder of insurance policy:_____ Date of Birth:_____/_____/_____

ID#:_____ Group#:_____ Effective Date:_____

We would like to thank our doctors & patients who refer to Whitney Chiropractic. Please let us know who referred you: _____

**Complaints/Symptoms**

**Please Circle your complaint and check what symptoms apply.**

| **Complaint** | **Pain Level (1 – 10)** | **Tingling** | **Numbness** | **Burning** | **Stabbing** | **Achy** | **Tight** |
|---|---|---|---|---|---|---|---|
| Neck | | | | | | | |
| Mid-Back | | | | | | | |
| Low-Back | | | | | | | |
| Hip R L | | | | | | | |
| Knee R L | | | | | | | |
| Shoulder R L | | | | | | | |
| Foot R L | | | | | | | |
| Wrist R L | | | | | | | |
| Ankle R L | | | | | | | |
| Elbow R L | | | | | | | |
| Finger _____ | | | | | | | |
| Jaw | | | | | | | |
| Other _____ | | | | | | | |

**History of Condition**

Purpose of todays appointment:_____

Have you been treated by a chiropractor before? Please circle Yes No

How long have you had this condition(s)?_____

Have you had this condition(s) before? Please circle Yes No If yes, how long ago?____

If yes, have you been treated by a chiropractor for this condition(s) before? Please circle Yes No

Have you seen any other doctors for this condition(s) yet? Please circle Yes No

If yes, explain:_____

Have you had surgery on your condition? Explain_____

Do you know what triggered your condition(s)?_____

What activities aggravate your condition(s)?_____

What relieves your condition(s)?_____

Have you used: (Please circle) Ice Heat Steroids Motrin/Tylenol Pain Medication PT

Explain:_____

Is your condition(s) getting progressively worse? Please circle Yes No

Is your pain constant? ( Please circle) Yes No Does your pain come & go? Please circle Yes No

Does your condition effect your Work_____ Sleep_____ daily activities_____

Is your condition related to an auto injury or workman's comp? Please circle Yes No

**Family History**

Check what conditions apply to family members:

| | Diabetes | Heart | Kidney | Cancer | Clotting Disorders | Other/Explain |
|---|---|---|---|---|---|---|
| Mother | _____ | _____ | _____ | _____ | _____ | _____ |
| Father | _____ | _____ | _____ | _____ | _____ | _____ |
| Brother, # of ____ | _____ | _____ | _____ | _____ | _____ | _____ |
| Sister, # of ____ | _____ | _____ | _____ | _____ | _____ | _____ |

**My signature indicates that I have completed all patient information sheets to the best of my ability.**

Signature:_____ Date:_____

## WELLNESS EVALUATION

In medicine today, leaky gut aka intestinal permeability isn't typically diagnosed. However, that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition. Let's get started. Please check any that apply to you:

**Sub-Clinical Symptoms Including:**
- Headaches
- Migraines

**Hormone Imbalance Including:**
- PMS
- Emotional Imbalance

**Gastrointestinal Issues Including:**
- Abdominal bloating, cramps or painful gas
- Irritable Bowel Syndrome
- Ulcerative Colitis
- Crohn's Disease and other intestinal disorders

**Respiratory Conditions Including:**
- Chronic sinusitis
- Asthma
- Allergies

**Joint Conditions Including:**
- Knee, Shoulder or Spine

**Autoimmune Conditions Including:**
- Diabetes Mellitus
- Lupus
- Rheumatoid Arthritis
- Fibromyalgia
- Chronic Fatigue

**Thyroid Conditions Including:**
- Hashimotos
- Hypothyroidism
- Hyperthyroidism

**Developmental and Social Concerns Including:**
- Autism
- ADD/ADHD

**Skin Conditions Including:**
- Eczema
- Skin rashes
- Hives

Circle the number that most closely fits, then add up your results.

| | NEVER | RARELY | SOMETIMES | OFTEN | ALWAYS |
|---|---|---|---|---|---|
| Constipation and/or diarrhea | 0 | 1 | 2 | 3 | |
| Abdominal pain or bloating | 0 | 1 | 2 | 3 | |
| Mucous or blood in stool | 0 | 1 | 2 | 3 | |
| Joint pain or swelling, arthritis | 0 | 1 | 2 | 3 | |
| Chronic or frequent fatigue or tiredness | 0 | 1 | 2 | 3 | |
| Food allergies, sensitivities or intolerance | 0 | 1 | 2 | 3 | |
| Sinus or nasal congestion | 0 | 1 | 2 | 3 | |
| Chronic or frequent inflammations | 0 | 1 | 2 | 3 | |
| Eczema, skin rashes or hives (urticaria) | 0 | 1 | 2 | 3 | |

| | NEVER | RARELY | SOMETIMES | OFTEN | ALWAYS |
|---|---|---|---|---|---|
| Asthma, Hayfever, or airborne allergies | 0 | 1 | 2 | 3 | |
| Confusion, poor memory or mood swings | 0 | 1 | 2 | 3 | |
| Use of NSAIDS (Aspirin, Tylenol, Motrin) | 0 | 1 | 2 | 3 | |
| History of antibiotic use Alcohol | 0 | 1 | 2 | 3 | |
| consumption makes you feel sick Gluten | 0 | 1 | 2 | 3 | |
| sensitivity or Celiac's disease Nausea | 0 | 1 | 2 | 3 | |
| Weight issues | 0 | 1 | 2 | 3 | |
| | 0 | 1 | 2 | 3 | |
| | 0 | 1 | 2 | 3 | |

YOUR TOTAL _____

## Patient Quality of Life Survey

Please take several minutes to answer these questions so we can help you get better.

(Please check all that apply)

**01** How have you taken care of your health in the past?

- Medications
- Emergency Room
- Routine Medical
- Exercise
- Other (please specify): _____
- Nutrition/Diet
- Holistic Care
- Vitamins
- Chiropractic

**02** How did the previous method(s) work out for you?

- Bad Results
- Some Results
- Great Results
- Nothing Changed
- Did Not Get Worse
- Did Not Work Very Long
- Still Trying
- Confused

**03** How have others been affected by your health condition?

- No One Is Affected
- Haven't Noticed Any Problem
- They Tell Me To Do Something
- People Avoid Me

**04** What are you afraid this might be (or beginning) to affect (or will affect)?

- Job
- Kids
- Future Ability
- Marriage
- Self-Esteem
- Sleep
- Time
- Finances
- Freedom

**05** Are there health conditions you are afraid this might turn into?

- Family Health Problems
- Heart Disease
- Cancer
- Diabetes
- Arthritis
- Fibromyalgia
- Depression
- Chronic Fatigue
- Need Surgery

**06** How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

_____

_____

_____

**07** What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:

1. _____
2. _____
3. _____

**08** What are you most concerned with regarding your problem?

_____

_____

_____

_____

**09** Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

_____

_____

_____

_____

**10** What would be different/better without this problem? Please be specific.

_____

_____

**11** What do you desire most to get from working with us?

_____

_____

**12** What would that mean to you?

_____

_____

**Informed Consent to Chiropractic Adjustments and Care**

The Nature of the Chiropractic Adjustment

The primary treatment used by a chiropractor is spinal manipulative therapy. This, along with other therapies, is the procedure you will receive at Whitney Chiropractic. Hands or a mechanical instrument will be used upon your body in such a way as to move your joints. This may cause an audible “pop” or “click”, similar to cracking your knuckles. However, this audible noise is actually a release of air pressure from a compressed joint.

Side Effects and Probability of any Risks

Some patients have an increase in discomfort after an adjustment. If that should happen, ice should be applied to the area and rest it. Notify your doctor if this occurs. If you are out of town or unable to contact your doctor, contact the nearest emergency room.

There are risks to treatment including, but not limited to, muscle strains and sprains, disc injuries, broken ribs, and strokes. I do not expect the doctor to anticipate and explain all the risks and complications. I do wish to rely on the doctor to exercise judgement during the course of the procedure, which are in my best interests based upon the facts known at that time.

If any tests were performed outside of the office, Whitney Chiropractic will inform you of your results when they become available  at a future scheduled appointment.

I have read the above consent and have decided to receive treatment at Whitney Chiropractic. If I have any further questions, I will ask the doctor at the time of treatment.

Patients Name:_____

Patients Signature:_____ Date:____/_____/_____

Signature of guardian if patient is a minor:_____ Date:_____/_____/_____

# HIPPA Notice of Privacy Practices

## Whitney Chiropractic

## This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information. Please Review It Carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health Information (PHI) to carry out treatment, payment or health care options (TPO) and for other purposes that re permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operations of the physician’s practice, and any other use requires by law.

Treatment

We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. Fo example, we would disclose your protected health care information, if necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you may have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical student students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We also may call you by name in the waiting room when your physician is ready for you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law. Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Corners: Funeral Directors: and Organ Donation Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required uses and Disclosures: Under the law, we must make disclosures to you and when requires by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent.

Authorization and Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposed as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclose of your protected health information, your protected health information will not be restricted. Then you have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copay of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. I we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or the secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name:_____

Signature of patient:_____ Date:_____/_____/_____

Print Minors Name:_____

Signature of guardian if patient is a minor:_____

**Whitney Chiropractic Financial Policy**

**Private Insurance**: Your health insurance contract is between you and your insurance company. However, we will be glad to bill your insurance carrier for you and receive payment from them. If any problems occur in processing a claim, it is your responsibility to contact them and clarify membership. IT IS ULTIMATELY YOUR JOB TO KNOW YOUR COVERAGE! You remain responsible for your deductible, co-payment (due at time of service), balance, and any portion not overed by your insurance. FILING TO YOUR SECONDARY INSURANCE COMPANY IS YOUR RESPONSIBILITY. Have your secondary insurance reimburse you after paying Whitney Chiropractic any balance your primary insurance made you responsible for. Payment for supplies are due at time of service and are NOT refundable.

**Medicare**: We will bill Medicare and receive any payment from them. Medicare will automatically bill your secondary or supplemental insurance. Medicare only covers manipulation/adjustments done by the doctor. NO other services are covered by Medicare. You are responsible for any services Medicare does NOT cover. An ABN form will be used to inform you of any services and supplies not covered. Medicare also requires an exam but does not pay for it. These services will be due for payment at the time of your visit. If you have a deductible, you will be billed. Any co-payment with Medicare advantage is to be paid at time of service.

**Personal Injury**: If your care is related to an automobile accident, we will bill the medical insurance company you provide. We will receive direct payment from this insurance. We will contact the insurance company you have provided. Any unpaid portion or denied charges are your responsibility to pay. Supplies are to be paid at time of service and are not refundable. It is your responsibility to keep in touch with the insurance to make sure your charges are paid. Once a personal injury is closed, you have one month to get any outstanding bills paid by the insurance company. If the balance is not paid by the insurance company in one month, the balance is required to be paid by you. If an attorney is involved, the attorney can reimburse you.

**Workers' Compensation**: If your care is related to an on-the-job injury and is recognized by your employer and/or insurance company, we will bill your employer's workers' compensation insurance company or responsible insurance. We will receive direct payment from this insurance. We will contact the insurance company you have provided. Any unpaid portion or denied charges are your responsibility to pay. Supplies are to be paid at time of service and are not refundable. It is your responsibility to keep in touch with the insurance to make sure your charges are paid. Once a personal injury is closed, you have one month to get any outstanding bills paid by the insurance company. If the balance is not paid by the insurance company in one month, the balance is required to be paid by you. If an attorney is involved, the attorney can reimburse you.

**Self-pay**: Your responsible for services rendered and supplies at time of service. We accept cash, checks, and a variety of credit cards. If you choose to join ChiroHealth USA because you do NOT have health insurance, a one-time fee of $49 is required at your first appointment every year to receive discount benefits on all services for you and all family members living in the same household. If you choose not to join ChiroHealth USA at your first appointment, NO DISCOUNT will be given on any services rendered. NO EXCEPTIONS!

**Financial Agreement**

As a courtesy to you, we will be happy to verify your insurance coverage and prepare any necessary reports and forms to assist in collecting payment from your insurance company. Whitney Chiropractic will only bill your insurance company once. Please be aware that verification of insurance coverage is not a guarantee of payment, but rather a quote of benefits.

I understand that if my insurance company does not cover my dates of service, I am ultimately responsible for my bill. I also understand that Whitney Chiropractic does not bill secondary or supplemental insurance companies.

I understand that my Guarantee of Payment will be used for any late balances of 30 days as well as any dates of service not paid by my insurance company. Personal injuries and Workman's Compensation will be paid by the patient after the case is closed after one month.

My attorney and/or insurance company are hereby requested and authorized pay direct to Whitney Chiropractic any money due on my account, the same to be deducted from any settlement made on my behalf. If I am offered a settlement and choose not to accept it, I will pay the balance in full within 30 days. Whitney Chiropractic will not wait for my claim to be settled.

I agree to pay Whitney Chiropractic the difference, if any, between the total amount charged and the amount paid by the insurance company and /or the attorney. It is further understood that I, the undersigned, agree to pay Whitney Chiropractic the full amount of charges should my condition be such that it is not covered by my policy, or if for any reason the insurance company refuses to pay my claim. I understand and agree that if my balance is outstanding for three consecutive months, it will be turned over to a credit agency or an attorney. I agree to pay a ten percent interest charge, as well as pay for any fees that may be charged by the collection agency or attorney.

I also agree that if I suspend treatment for any reason, I will pay the balance due on my account at that time.

No credit will be issued on my account if any other family members have a balance.

Name of patient:_____

Signature of patient:_____

Date:_____/_____/_____

Signature of guardian if patient is a minor:_____

**Guarantee of Payment**

**A Guarantee of Payment: (GOP) is REQUIRED for ALL patients**. ANY unpaid balances or denied charges are put on your "GOP" after 30 days of closing any accounts on Personal injury and/or Worker's compensation cases or becoming 30 days late on any private insurance accounts or self-pay accounts.

To help us provide you with the best healthcare, Whitney Chiropractic implements a payment guarantee program. We request a credit card to be placed on file for any patient's outstanding balances over 30 days late. This is money you owe to Whitney Chiropractic, not money that is owed by your insurance company. If your credit card expires at any future visits, we will request your credit card to be updated. If this card is used for any late balances, you will see the charge on your statement. This preauthorizes Whitney Chiropractic to process any late balances directly to the credit card you provide. Therefore, your outstanding bill will be processed in the most effective timely manner and allow us to focus on more important issues, such as your health.

I hereby authorize Whitney Chiropractic to charge my credit card for any 30-day late patient's balances or denied/unpaid charges.

Print Name:_____

Signature:_____

Dare:_____/_____/_____

**PLEASE PROVIDE OUR RECEPTIONIST WITH THE FOLLOWING:**

1. Insurance Card
2. Driver's license of patient or parent if patient is a minor
3. Credit card (NO American Express)