Patient Registration and Health History

Date:_____

Name:_____ Home Phone:_____

Address:_____ Cell Phone:_____

City:_____State:_____Zip:_____ Date of Birth:_____Age:_____

Email:_____ Gender: Male Female

Employer/School:_____ Marital Status: S M D W

Occupation:_____ Spouse's Name:_____

Number of Children:_____

Please describe your purpose of this appointment?_____

_____

Date symptoms appeared or injury occurred?_____

List any other doctors seen for this problem:_____

List other diagnosis, health conditions or treatments in past 10 years. Please include any major surgeries or illnesses:

_____

_____

_____

What medications are you currently taking?_____

_____

_____

Do you have allergies to any medication? **Yes** **No** If yes, please describe:_____

Do you have any other allergies? **Yes** **No** If yes, please describe:_____

Have you received chiropractic or acupuncture treatment previously? **Yes** **No**

If yes, please explain your experience:_____

_____

How were you referred to our office?_____

May we include you on our email list for you to receive occasional updates from our office only? **Yes** **No**

Please continue Health History on back

Indicate with an **N** if you are currently experiencing this condition or **P** if you have had this condition in the past.

N=Now P=Past

MUSCULO-SKELETAL SYSTEM

___ Low back problem
___ Pain between shoulders
___ Neck problems
___ Jaw pain
___ Arm problems
___ Leg problems
___ Swollen joints
___ Painful or stiff joints
___ Sore muscles
___ Weak muscles
___ Walking issues
___ Ruptures
___ Broken bones
___ Scoliosis
___ Rheumatoid arthritis

GENITO-URINARY SYSTEM

___ Bladder trouble
___ Kidney conditions
___ Excessive urine
___ Painful urination

GASTRO-INTESTINAL SYSTEM

___ Poor Appetite
___ Ulcers
___ Difficulty swallowing
___ Excessive thirst
___ Nausea
___ Indigestion/Reflux
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Abnormal stools

NERVOUS SYSTEM

___ Numbness/Loss of feeling
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches/Migraines
___ Muscle jerking
___ Convulsions/Seizures
___ Forgetfulness/Confusion
___ Loss of balance

CARDIOVASCULAR-RESPITORY

___ Chest pain
___ Asthma
___ Difficulty breathing
___ Persistent cough
___ Cold feet/hands
___ Heart conditions
___ Heart arrhythmias
___ Blood Pressure regulation
___ Lung conditions
___ Varicose veins
___ Fatigue

EYE, EAR, NOSE, THROAT

___ Eye issues/inflammation
___ Vision issues/loss
___ Ear conditions
___ Hearing issues/loss
___ Nose conditions
___ Sinus difficulties/pain
___ Dental/Mouth conditions

OTHER SYSTEMs

___ Thyroid conditions
___ Anemia/Blood conditions
___ Skin conditions
___ Psychiatric care

FEMALES

Are you currently pregnant?
Yes No
How many pregnancies have you had? _____
___ Menstrual issues
___ Menopausal issues
___ Fertility issues
___ Breast issues
___ Osteoperosis

MALES

___ Prostate issues
___ Low Testosterone

SOCIAL HISTORY

O=Often
S=Sometimes
N=Never

___ Vigorous Exercise
___ Moderate Exercise
___ Alcohol use
___ Drug use
___ Tobacco use
___ Caffeine
___ High Stress
___ Difficulty Sleeping
___ Changes in Energy level
___ Family pressures
___ Work-related pressures
___ Financial pressures
___ Emotional/Mental stress
___ Other (specify)
_____
_____
_____

Patient Name (printed):_____

Informed Consent to Chiropractic Treatment:

Please read the entire ***Informed Consent to Treat*** document provided to you prior to signing. It is important that you understand the information regarding chiropractic manipulation and therapy. Please ask any questions before you sign if there is any information that is unclear to you.

By signing below, I acknowledge that I have read the ***Informed Consent to Treat*** document that explains the nature of chiropractic adjustment and related treatments. I confirm that I have reviewed this document regarding chiropractic care and considered the risks involved in receiving chiropractic care by Nikanth/ Dr. Tammy St. John, DC.

I hereby give my consent to chiropractic treatment.

Patient's Signature:_____ Date:_____

Signature of Parent/Guardian for a minor:_____

Notice of Privacy Practices Acknowledgement:

Please read the entire **Notice of Privacy Practices** document provided to you prior to signing. It is important that you understand the information regarding our practice's commitment to your health privacy as required by the Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA.

By signing below, I acknowledge that I have been provided a copy of the ***Notice of Privacy Practices*** which outlines my rights and disclosures under HIPPA guidelines. I confirm that I have reviewed this document and agree that Nikanth/Dr. Tammy St. John, DC may use or disclose my health information for the purpose of providing treatment, coordination of care and for purposes relating to receiving payment for services rendered.

I hereby acknowledge and agree with your Privacy Practices.

Patient's Signature:_____Date:_____

Signature of Parent/Guardian for a minor:_____

Financial Policy:

Please read the entire **Financial Policy** document provided to you prior to signing. It is important that you understand the information regarding our practice's policy on receiving payment for services provided to you, including additional fees for outstanding balances due.

By signing below, I acknowledge that I have read and understand this practice's ***Financial Policy.*** I authorize and release all information necessary to secure payment from insurance and other third-party payors of benefits on my behalf to Nikanth/ Dr. Tammy St. John, DC. I understand that I am ultimately responsible for all costs of my chiropractic care regardless of insurance or third -party benefits.

I hereby acknowledge and agree to your Financial Policy.

Patient's Signature:_____ Date:_____

Signature of Parent/Guardian for a minor:_____

Witness Signature:_____ Date:_____

Informed Consent to Chiropractic Treatment

As a Doctor of Chiropractic, the primary treatment I use is spinal manipulative therapy (s). I may use my hands or instruments on your body in such a way as to move your joints and/or muscles. As part of your treatment, I may use Interferential Current (IFC) therapy, Ultra Sound, palpation and range of motion analysis.
As an acupuncturist, I may use sterile disposable needles.

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy/acupuncture. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should be advised:

1. Some patients may experience some stiffness or soreness following the first few days of treatment.

2. Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.

3. I will make every effort to screen for any contraindications to care; however, if you have an underlying condition that would not otherwise come to my attention, it is your responsibility to inform me.

4. Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations or burns.

5. Acupuncture treatment may have some side effects including bruising, numbness or tingling near the needling sites. Although rare and remote, some risks include dizziness, fainting, or nerve damage. If you are pregnant, please advise doctor prior to receiving <u>any</u> acupuncture procedure.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination and x-rays (when warranted).

By signing, I acknowledge that I have the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all of my present and future chiropractic care.

Patient signature_____ Date:_____

Witness Signature_____ Date:_____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to that information. Please review this notice carefully.
This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated

No Consent Required

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.

(b) Payment – In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

1. The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as an associate doctor, billing company or massage therapist that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative -To a person who, under applicable law, has the authority to represent you in making decisions related to your health care

(d) Emergency Situations:

(i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

(ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence – To a government authority if the Practice is required by law to make such disclosure; if the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm

(h) Health Oversight Activities – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

FINANCIAL POLICY

Please understand that payment of your bill is considered part of your care.
The following is a statement of our Financial Policy, which we require that you read and sign prior to providing services.

PAYMENT IS DUE AT THE TIME OF SERVICE

We accept cash, check, Visa, MasterCard, Discover and Health Savings Accounts
Financial assistance is available for consideration.

Regarding Commercial Health Insurance:
Your insurance policy is a contract between you and your insurance company. We are not party to that contract. We will accept assignment of insurance benefits with confirmed commercial insurance coverage with an insurance company who has maintained good credit with Dr. Tammy Chiropractic. We reserve the right to deny certain Health Insurance plans.
You are responsible for payment of the first visit in full. If we agree to process insurance on your behalf, you are required to pay your co-pay and co-insurance portion at each subsequent visit**. PPO/HMO** patients are responsible for all co-pays, co-insurances, in addition to the difference between benefits paid by your insurance carrier and minimums due for each service provided regardless of contractual in or out- of- network benefits.
Medicare patients may be required to pay non-covered services at the time of service.

Worker's Compensation:
If your condition is the result of a work related injury, we will bill your work comp insurance provided you have the claim number and contact information with you on the first visit. We also require your commercial health insurance information in case there is a problem with your claim. You understand that you are ultimately responsible for the payment of your services as noted above regarding your commercial health insurance.

Automobile (Personal) Injuries:
If your condition is the result of an automobile accident, we will bill your automobile medical pay insurance. If medical pay is not available, we may submit the claims to your personal health carrier. If third party liability cannot be confirmed, we will require payment in full at the time services are rendered. (Refer to Billing Policy)

Minors:
Parents and/or legal guardians are required to accompany a minor at the time services are rendered. For unaccompanied minors, non-emergency treatment will be denied.

Missed Appointments:
We ask for the courtesy of canceling scheduled appointments 24 hours in advance. Please help us to serve you and our other patients by keeping your scheduled appointments. If appointments are chronically missed without sufficient notice, we reserve the right the charge a fee for those missed appointments.

Billing Policy:
I understand that I will be expected to pay fees due at the time of service. Fees for services are posted at our reception desk. If we have agreed to accept and process commercial insurance on your behalf, fees include any non-covered services, co-pays and co-insurance per your insurance contract. I understand that I will be billed if there is a balance due after my insurance has been reconciled. I understand that I am responsible to pay any and all balances remaining after 60 days from the date that services are rendered. I also understand that if late, legal or collection fees are activated on past due balances after 60 days from the date(s) of service, all costs including late fees, attorney's fees and collection fees will be in addition to the balance due and the responsibility of the patient.

If we accept assignment from your insurance company, or any liable third party, we maintain the right to demand full payment from you, the patient, for any reason your balance from services performed has not been paid in full within 60 days from the date(s) of service.

I understand and agree to the terms of this financial policy.

Patient Signature Date