



## Patient Health Record

### About the Patient

Legal Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Gender \_\_\_\_ Marital Status \_\_\_\_\_ Number of Children \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License Number \_\_\_\_\_

Employer \_\_\_\_\_ Type of Work \_\_\_\_\_

### Contact Information

Preferred Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Type of phone number:  Cell  Landline  Work

Would you like to receive Text Reminders?  Yes  No

Email Address \_\_\_\_\_

Would you like to receive Opp Family Chiropractic Monthly Newsletter?  Yes  No

### **Who may we thank for referring you to our office?**

\_\_\_\_\_

### Primary Insured

Name \_\_\_\_\_ Employer \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I certify that the information provided is correct to the best of my knowledge

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. For an example; the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of the PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a Privacy Official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our Privacy Official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations; the chiropractic physician has the right to refuse to give care.

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I agree to allow Opp Family Chiropractic to leave voice messages on my phone containing personal information.

Yes  No

Check all phone numbers that apply:

Cell Phone  Home Phone  Work Phone  Other: \_\_\_\_\_

I agree to allow Opp Family Chiropractic to send me emails containing personal information.

Yes  No

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Printed Name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Relationship to Patient (if under age 18): \_\_\_\_\_

### Automobile Accident Questionnaire

**Nature of Accident**

What was the time and date of this present injury? \_\_\_\_\_

Please explain in detail how your accident happened: \_\_\_\_\_

Type of vehicle you were in/driving: \_\_\_\_\_ Type of other vehicle or object: \_\_\_\_\_

Were you: Driver Passenger Front Seat Back Seat Were you wearing a seat belt? Yes No

What was the speed of your vehicle? \_\_\_\_\_ Did an air bag deploy? Yes No Did your head hit the head rest? Yes No

Where were you looking at the time of impact? Right Left Forward Over R Shoulder Over L Shoulder

Did you come in contact with any objects in the car? Yes No

If yes, what objects? (i.e. windshield, etc.) \_\_\_\_\_

What parts of your body came in contact with the above object(s)? \_\_\_\_\_

Were you unconscious as a result of the injury? Yes No

If yes, how long? \_\_\_\_\_

What part of the vehicle is damaged? \_\_\_\_\_

Was there vehicle impact? Yes No

Was the patient's vehicle moving? Yes No

The patient's vehicle was/going: Forward Reverse Turning Stopped

What was the other vehicle/object's movement? \_\_\_\_\_

If applicable, what was the speed of the other vehicle? \_\_\_\_\_

Was the other vehicle/object damaged? Yes No

Was the car towed? Yes No

Do you have an estimate on the damage? Yes No

If so, how much? \_\_\_\_\_

Were the police notified? Yes No

Was a report taken? Yes No

Was EMS at the scene? Yes No

Where did you go after the accident? \_\_\_\_\_ How did you get there? \_\_\_\_\_

What treatment have you had since the accident? \_\_\_\_\_

Are you having any symptoms as a result of the accident? \_\_\_\_\_ Was any other doctor consulted after your accident? Yes No

If yes, what is the doctor's name? \_\_\_\_\_ DC MD DO DDS

Describe the doctor's diagnosis: \_\_\_\_\_

What treatment did you receive, if any? \_\_\_\_\_

Are you still under a doctor's care? Yes No

If yes, please explain: \_\_\_\_\_

Show area(s) of pain or unusual feeling immediately after accident. Mark the areas on this body where you felt the describing sensations. Use appropriate symbols in all affected areas

Numbness	Pins & Needles	Burning	Aching	Stabbing
xxxxxx	••••••	ooooo	vvvvv	
xxxxxx	••••••	ooooo	vvvvv	
xxxxxx	••••••	ooooo	vvvvv	

**Past History**

Have you ever injured this area before?    Yes    No

If yes, please explain: \_\_\_\_\_

Have you been involved in any previous accidents of any kind? (Personal injury, auto accident or workers' comp.)    Yes    No

If yes, please explain dates and details: \_\_\_\_\_

Have you enjoyed good health prior to this accident?    Yes    No

If no, please explain (i.e. illness or injuries) \_\_\_\_\_

**Present Information/Disability**

Have you returned to work?    Yes    No    If yes, date returned? \_\_\_\_\_

Job description \_\_\_\_\_

Are your work activities restricted as a result of this accident?    Yes    No    If yes, please explain \_\_\_\_\_

Do you notice any activity restrictions as a result of this accident?    Yes    No

If yes, please explain \_\_\_\_\_

Since this injury are your symptoms:    Improving    Getting worse    Same

**Legal Representation**

Have you retained an attorney?    Yes    No

If yes, name and address: \_\_\_\_\_

Have you contacted your insurance company regarding this incident?    Yes    No    Claim Number: \_\_\_\_\_

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.

Patient's Printed Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature (Upon review) \_\_\_\_\_ Date \_\_\_\_\_

# Functional Rating Index

In order to properly assess your condition, we must understand how much your neck/back problems have affected your ability to manage everyday activities.

For each item below, **please circle the number** which most closely describes your condition right now.

Patient Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Today's Date: \_\_\_\_\_

## Pain Intensity

0	1	2	3	4
No Pain	Mid Pain	Moderate Pain	Severe Pain	Worst Pain Possible

## Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep

## Personal Care (Washing, dressing, etc.)

0	1	2	3	4
No Pain; No Restrictions	Mild Pain; No Restrictions	Moderate Pain; Need to go Slowly	Moderate Pain; Need Some Assistance	Severe Pain; Need 100% Assistance

## Travel (driving, ect.)

0	1	2	3	4
No Pain on Long Trips	Mild Pain on Long Trips	Moderate Pain on Long Trips	Moderate Pain on Short Trips	Severe Pain on Short Trips

## Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

## Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

## Frequency of Pain

0	1	2	3	4
No Pain	Occasional Pain; 25% of the day	Intermittent Pain; 50% of the day	Frequent Pain; 75% of the day	Constant Pain; 100% of the day

## Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

## Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

## Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

**Total** \_\_\_\_\_

## Patient Financial Responsibility Policy

Opp Family Chiropractic appreciates your confidence in choosing us to provide for your healthcare needs. We are committed to providing you with the best possible care for your total body wellness. The treatment you have elected to participate in includes a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our services. Contact your insurance company to determine what is covered and what is not. You are ultimately responsible for payment of any services and care received at Opp Family Chiropractic whether they are covered by your insurance company or not. Be sure to bring your insurance card to each visit. Always notify our office of any changes to your insurance. And lastly, be prepared to pay any portions your insurance company does not cover.

### **Co-Pays and Deductibles**

If your insurer requires you to pay a co-pay or deductible, please be aware of the amount of your co-pay or deductible at the time of services. You will be asked to pay all co-pays or deductibles at the time of service. If you do not pay your co-pay or deductible at the time of service, we will bill you and may charge you a reasonable service fee to offset the cost of sending you a statement. All bills are due within seven (7) days of the date it was mailed or emailed to you.

### **Cancellation / No Show Policy**

When you make an appointment, we reserve time specifically for you. Unfortunately, when a patient does not show for their scheduled appointment, another patient loses an opportunity to be seen. Therefore, if you need to cancel or re-schedule, you are asked to notify us as soon as possible, but no later than 24 hours in advance. Appointments cancelled without 24 hours notice may be assessed a cancellation fee of \$25. Habitually cancelling appointment may cause us to ask you to seek another chiropractor for your healthcare needs.

### **Failure to Meet Financial Responsibility**

If you fail to meet the financial obligations agreed upon in this policy and acknowledgment, your outstanding balance will be sent to a collection agency and the balance will have to be paid before receiving further treatment. Your future status with this office will be considered at that time and may lead to being discharged from care at Opp Family Chiropractic. If you have any questions, please contact the billing department.

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### **Patient Acknowledgment**

I have read and understand Opp Family Chiropractic's Patient Financial Responsibility Policy. I agree to assign insurance benefits to Opp Family Chiropractic whenever necessary. I authorize Opp Family Chiropractic to release information to a collection agency or attorney in the event I don't fulfill my financial responsibilities. I understand that if I fail to meet my financial obligations to Opp Family Chiropractic then I will be responsible for all costs and reasonable collection and/or attorney fees. I expressly authorize Opp Family Chiropractic to charge any outstanding balance, due to co-pays, deductible or non-covered services, on my credit/ debit card pursuant to the terms I agreed to in this Acknowledgement and the Patient Payment Authorization I signed.

I would like Opp Family Chiropractic to (check all the apply):

Mail my billing statement to:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Email my billing statement to:

Email address: \_\_\_\_\_

Printed Name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## Patient Payment Authorization

### Explanation of Automated Recurring Payment option

Opp Family Chiropractic offer an automated payment option to our patients for their convenience. If you (a patient or payer on behalf of a patient) return this completed Patient Payment Authorization, we will automatically charge your credit/debit card for any outstanding balance due to co-pays, deductibles or non-covered services.

By my signature below, I authorize Opp Family Chiropractic P.A. to process my debit/credit card for 100% of the patient's outstanding balance in full if after seven (7) days of the receipt of an emailed or mailed billing statement a balance remains owing for co-pays, deductibles or non-covered services. I understand I may revoke this authorization by giving my notice in writing to Opp Family Chiropractic.

This authorization is to remain in full force and effect until all amounts owed related to the treatment rendered to the patient are paid in full, or until I cancel this authorization. To cancel, I must notify Opp Family Chiropractic in writing and give reasonable opportunity to act.

I agree that Opp Family Chiropractic, in its sole discretion, may terminate this agreement if my account should lack sufficient funds for payment. In the event Opp Family Chiropractic is unable to secure funds from my bank account or credit card for any reason, I may be charged for further collection action that may be undertaken to the full extent provided my law.

Check here if you would like a phone call before we charge your account

Check here if you would like us to charge your account without a phone call

Name on Card: \_\_\_\_\_

Billing Street Address: \_\_\_\_\_

Billing City, State, Zip: \_\_\_\_\_

Type of Card:  Visa  MasterCard  Discover  Other: \_\_\_\_\_

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CVV Code: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Cardholder Printed Name: \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_