



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.

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): _____

Name _____ D.O.B. ____ / ____ / ____ Date ____ / ____ / ____

Health History

Reason for office visit:

Date began:

List current health problems for which you are being treated:

What types of therapies have you tried for these problem(s) or to improve your health over-all? (Check all that apply)

- Diet modification Fasting Vitamins/Minerals Rx Drugs Homeopathy Chiropractor Acupuncture Conventional Drugs

Other _____

Do you experience any of these general symptoms every day? None

- Bleeding
- Depression
- Disinterest in eating
- Insomnia
- Panic attacks
- Chronic pain/Inflammation
- Diarrhea
- Dizziness
- Itching/rash
- Shortness of breath
- Constipation
- Discharge
- Fecal incontinence
- Low grade fever
- Urinary Incontinence
- Debilitating fatigue
- Disinterest in sex
- Headaches
- Nausea
- Vomiting

Current medications (prescribed or over-the-counter):

Current vitamins and supplements:

Lab procedures performed (e.g. stool/hair analysis, blood/urine chemistries)

Outcome

Please list any major hospitalizations, injuries or procedures including complications (if any) and dates:

Year

Surgery, Illness, Injury

Outcome

Are you Pregnant? _____ Are you recovering from a cold or flu? _____

What is your current level of stress on a scale of 1 to 10 (1 being the lowest): _____

Identify the major causes of stress (e.g. changes in job, work, finances, legal problems): _____

Do you consider yourself: underweight overweight just right Your weight today: _____

Have you had unintentional weight loss or gain of 10 pounds or more in the last three months? Yes No

Is your job associated with potentially harmful chemicals or health and/or life threatening activities? Yes No

Medical History (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Allergies/hay fever | <input type="checkbox"/> Kidney or Bladder Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Learning disabilities |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Liver or Gallbladder Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Mental retardation |
| <input type="checkbox"/> Blood pressure problems | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Neurological
(Parkinson's, paralysis) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Cholesterol, elevated | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Seasonal Affective Disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diverticular Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Epilepsy | |
| <input type="checkbox"/> Emphysema | |

Medical - Men

- | | |
|--|---|
| <input type="checkbox"/> Eyes, ears, nose, throat problems | <input type="checkbox"/> Benign Prostatic Hyperplasia |
| <input type="checkbox"/> Environmental sensitivities | <input type="checkbox"/> Prostate cancer |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Decreased sex drive |
| <input type="checkbox"/> Food intolerance | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Gastroesophageal Reflux Disease | Other _____ |
| <input type="checkbox"/> Genetic disorder | _____ |

Medical - Women

- | | |
|---|---|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Menstrual Irregularities |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Infection, chronic | <input type="checkbox"/> Fibrocystic breast |
| <input type="checkbox"/> Inflammatory Bowel Disease | |

- | | |
|--|--|
| <input type="checkbox"/> Fibroids/ovarian cysts | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Premenstrual Syndrome (PMS) | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Pelvic Inflammatory Disease | <input type="checkbox"/> Learning disabilities |
| <input type="checkbox"/> Vaginal infections | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Decreased sex drive | <input type="checkbox"/> Mental retardation |

Date of last GYN exam _____

Mammogram + -

PAP + -

Form of birth control _____

Number of children _____

Number of pregnancies _____

C-section _____

Age of first period _____

Date - last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g. heavier, large clots, scanty) _____

- | | |
|---|---|
| <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> (Parkinson's, paralysis) |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Suicide | <input type="checkbox"/> Stroke |
| Other _____ | <input type="checkbox"/> Suicide |

Health Habits

Tobacco:

Cigarettes/day _____

Cigars/day _____

Other: _____

Alcohol:

Wine: glass/d or wk _____

Beer: glass/d or wk _____

Liquor: oz/d or wk _____

Family Health History (Parents and Siblings)

- | | |
|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Coffee: 6oz cups/d _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Tea: 6oz cups/d _____ |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Soda: cans/d _____ |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Other Sources: _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Water: glasses/d _____ |
| <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Drug addiction | |
| <input type="checkbox"/> Eating disorder | |
| <input type="checkbox"/> Genetic disorder | |

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.

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: _____