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:_____ **Date:**_____ **D.O.B.:**_____

Workers' Compensation Questionnaire

Nature of Accident

What was the time and date of this present injury?_____

Please explain in detail how your accident happened. (Please include location, condition of area and equipment involved.)

_____

_____

Where did you feel pain or unusual feeling immediately after the accident?

_____

_____

Were you unconscious as a result of the accident? Yes☐ No☐

Were you bleeding as a result of the accident? Yes☐ No☐

Did you leave the work area after the accident to seek medical attention? Yes☐ No☐

Please explain_____

Did you consult any other doctor? Yes☐ No☐ Doctor's Name _____

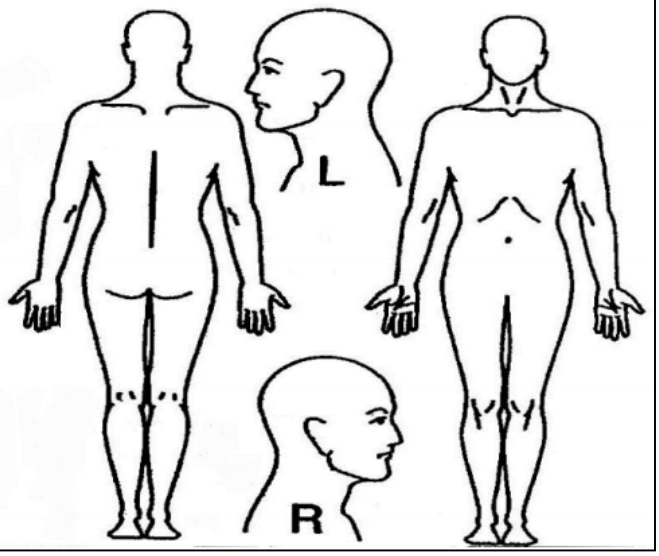
Describe the doctor's diagnosis _____

What treatment, if any, did you receive?_____

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	IIIIIIII



Past History

Have you ever injured this area before? Yes☐ No☐ If yes, when? _____

If injured before, did you lose time from work? Yes☐ No☐

If you lost time from work with injuries prior to this injury, give the name of the doctor or doctors consulted_____

_____

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

If yes, please explain dates and details_____

Present Information / Disability

Have you returned to work? Yes☐ No☐ If yes, date returned_____

Job description _____

Do you favor any part of your body while at work? Yes☐ No☐

If yes, please explain _____

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

If yes, please explain_____

Since this injury are your symptoms Improving☐ Getting worse☐ Same☐

Do any other diseases or accidents affect your employment? Yes☐ No☐

If yes, please explain _____

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 No Pain	1 Mid Pain	2 Moderate Pain	3 Severe Pain	4 Worst Pain Possible
Sleeping				
0 Perfect Sleep	1 Mildly Disturbed Sleep	2 Moderately Disturbed Sleep	3 Greatly Disturbed Sleep	4 Totally Disturbed Sleep
Personal Care (Washing, dressing, etc.)				
0 No Pain; No Restrictions	1 Mild Pain; No Restrictions	2 Moderate Pain; Need to go Slowly	3 Moderate Pain; Need Some Assistance	4 Severe Pain; Need 100% Assistance
Travel (driving, ect.)				
0 No Pain on Long Trips	1 Mild Pain on Long Trips	2 Moderate Pain on Long Trips	3 Moderate Pain on Short Trips	4 Severe Pain on Short Trips
Work				
0 Can do usual work plus unlimited extra work	1 Can do usual work; no extra work	2 Can do 50% of usual work	3 Can do 25% of usual work	4 Cannot work
Recreation				
0 Can do all activities	1 Can do most activities	2 Can do some activities	3 Can do a few activities	4 Cannot do any activities
Frequency of Pain				
0 No Pain	1 Occasional Pain; 25% of the day	2 Intermittent Pain; 50% of the day	3 Frequent Pain; 75% of the day	4 Constant Pain; 100% of the day
Lifting				
0 No pain with heavy weight	1 Increased pain with heavy weight	2 Increased pain with moderate weight	3 Increased pain with light weight	4 Increased pain with any weight
Walking				
0 No pain; any distance	1 Increased pain after 1 mile	2 Increased pain after 1/2 mile	3 Increased pain after 1/4 mile	4 Increased pain with all walking
Standing				
0 No pain after several hours	1 Increased pain after several hours	2 Increased pain after 1 hour	3 Increased pain after 1/2 hour	4 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 send 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 willbe 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 alj 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: _____