

Collins Chiropractic Clinic

Patient Information

In order to provide you the best possible chiropractic care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name _____ Date _____ Referred by _____

Mailing address

Address _____ City _____ State ____ Zip _____

Telephone (home) _____ (work) _____ (cell) _____

Age _____ Birth date _____ Social Security # _____ Number of children _____

Occupation _____ Employer _____

Marital Status _____ Spouse's name _____ E-mail _____

Emergency contact _____ Phone _____

Current Complaints

Reason for today's visit: Automobile* Work Other

Please describe _____

Date of injury _____ Date symptoms appeared _____

Have you ever had same condition? No Yes If yes, when? _____

List other practioners seen for this injury/condition _____

Have you ever been under chiropractic care? No Yes

If yes, please describe _____

Insurance Information

Name of party responsible for payment _____ Phone _____

Do you have health insurance? No Yes Name of company _____

** If an auto accident please provide:*

Insurance company name _____ Contact person _____

Phone _____ Claim # _____

Billing Address

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? No Yes

If yes, please describe _____

Date of last physical exam _____ Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc). _____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).

Have you ever:

	No	Yes	Briefly Explain
Broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in an auto accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Sprains/Strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits:

	None	Light	Moderate	Heavy		Yes	No
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you experience pain every day?	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do your symptoms interfere with daily life?	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does pain wake you up at night?	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are your symptoms worse during certain times of the day?	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do changes in weather affect your symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear orthotics?	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you take vitamin supplements?	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What activities aggravate your symptoms?		
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Have you ever suffered from:

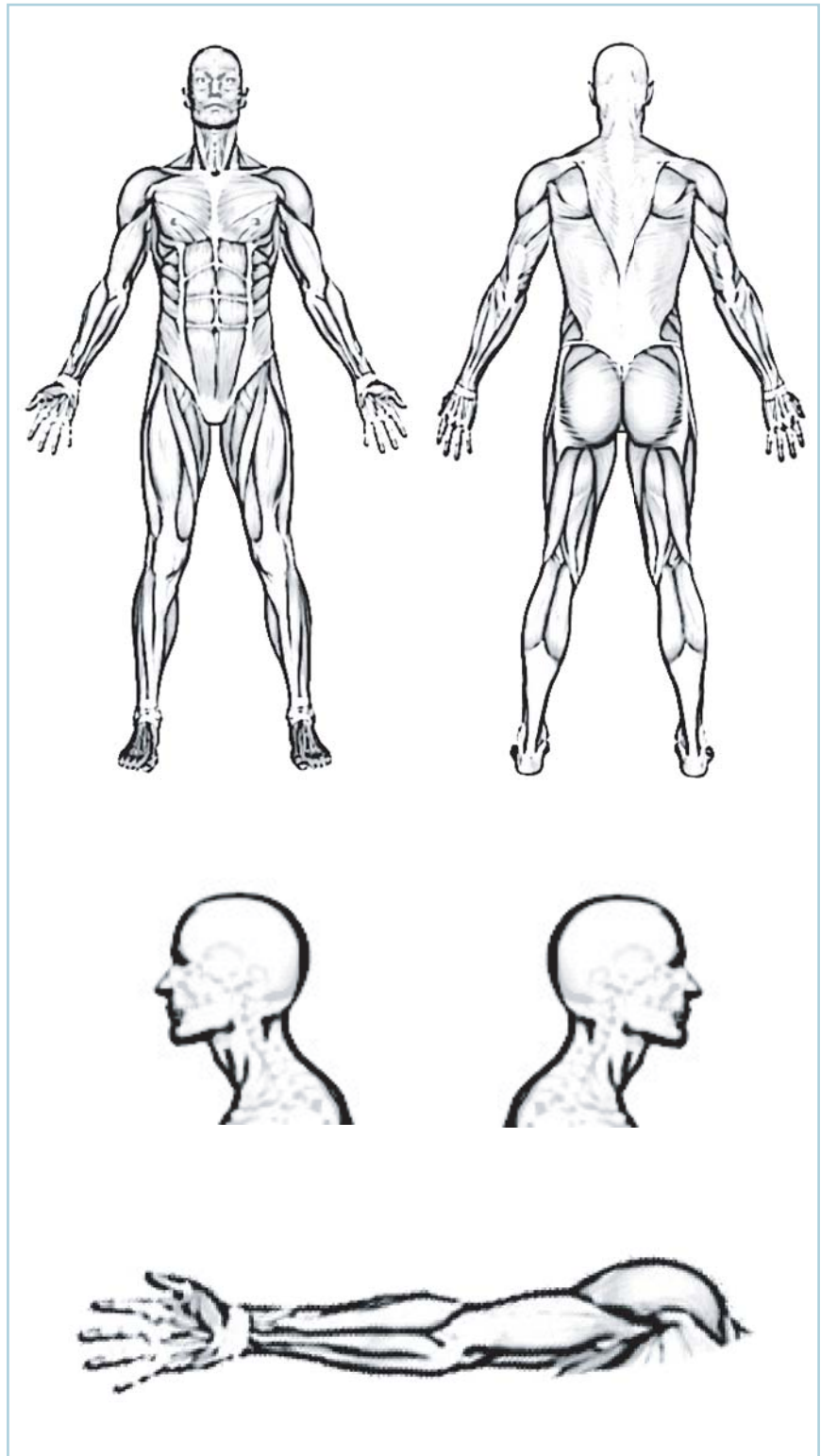
- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain/Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems/insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Current Complaints (Continued)

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness

O=Other
P=Pins & Needles
S=Stabbing



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Thank you for choosing this office to provide you with chiropractic care.

Office Policy

Appointment Policy:

Based on your x-ray and exam findings the doctor will prescribe a treatment plan. It is important that you follow the treatment plan so you may get the maximum results in a minimum amount of time. We make every attempt to stay on schedule to avoid long waiting periods, to assist us with this, please be on time for your appointment.

Financial Policy:

Co-payments and payments for services are due on the day the service is performed. As a courtesy to you, we will file claims with your insurance company, so you can afford to bring your family in for chiropractic care. Please note filing a claim does not guarantee payment from the insurance company and you remain responsible for all balances due on your account.

Informed Consent to Chiropractic Care

- I request and consent to the performance of chiropractic examination, adjustments and all other chiropractic procedures permitted by our state law, including medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible), by any of the treating doctor's chiropractic on staff, and/or any licensed chiropractor deemed appropriate by this office.
- I understand that results of treatment are not guaranteed.
- I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are risks associated with treatment, although rare, including, but not limited to, fracture, disc injuries, strokes, dislocations, strains, and worsening of symptoms.
- I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at that time, based on the facts then known, is in my best interest.
- This consent form covers the entire course of treatment for my present condition, and for any future condition(s) for which I seek treatment.

Print Patient's Name: _____

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____

Witness: _____ Date: _____

HIPPA Privacy Policy

A copy of the full HIPPA Privacy Policy was made available to me by this office.

Patient's Name: _____

Signature: _____ Date: _____

Notice of Privacy Practices for Protected Health Information

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.

Uses & Disclosures

We may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes:

- **Treatment Example:** We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.
- **Payment Example:** We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.
- **Health Care Operations Example:** We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

We may use or disclose your protected health information:

- If we provide services to you while you are an inmate.
- If we provide services to you in an emergency treatment situation.
- If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communication, and we determine, in the exercise of our professional judgment that you intend for us to treat you.
- If we need to notify, or assist in the notification of a family member, personal representative or another person responsible for your care of your location, general condition or death.
- If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.
- If we are required by law to disclose your health information to a public health or other governmental authority that is authorized to receive reports of child abuse or neglect.
- If we are required to disclose your health information to the Food and Drug Administration.
- If we are required to disclose your health information to your employer to evaluate whether you have a work related injury or illness.
- If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect or domestic violence.
- Disclosures made to individuals involved with your care;
- Disclosures made for national security or intelligence purposes;
- Disclosures made to correctional institutions or law enforcement officials; and
- Disclosures made prior to the compliance date of the HIPPA Privacy Rule.

Right to Receive Notice: You have the right to receive a paper copy of this notice, upon request.

Our Duties: We are required by law to maintain the privacy of protected health information and to provide you with a notice of legal duties and privacy practices with respect to your health information. We must abide by the terms of this notice, while it is in effect. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all of the health information that we maintain. If we make a change in the terms of this notice, we will notify you in writing and provide you with a paper copy of the new notice, upon request.

Complaints: You may complain to us and to the Secretary of Health Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address that follows. We will not take any action against you for filing a complaint.

How to Contact Us: If you would like further information about our privacy practices, please contact:

Garry Collins, D. C.
Collins Chiropractic Clinic
P. O. Box 322, Floyd, VA 24091 - 540-745-6494.

Effective Date of Notice: March 24, 2003