Confidential Patient Data

Name:______________________ ______________________ Preferred Name: ____________________
Last Name, First Name *M.I.*

Date of Birth:_______________________ Gender: ❑ Male ❑ Female
MM/DD/YYYY

Marital Status: ❑ Married ❑Single ❑Divorced ❑Widowed

Address:____
Street *Apt #* *City/State* *Zip Code*

Phone Numbers: Home: ____________________ Cell:___________________Other:_______________

Email:____

Appointment Reminders: ❑No ❑Yes If yes, ❑Text Reminders ❑E-mail Reminders ❑Both

Your Occupation______________________________Your Employer:____________________________

Emergency Contact:_________________________________Phone:____________________________

Who can we thank for referring you to our office: ❑Friend/Family Name:_________________________
❑Internet ❑Insurance Provider ❑Other ____

Medical History **Y=Yes N=No**

Do you have, or have you had any of the following:

Y	N		Y	N		Y	N	
❑	❑	AIDS	❑	❑	dislocated joints	❑	❑	neck pain
❑	❑	anemia	❑	❑	epilepsy	❑	❑	nervousness
❑	❑	arthritis	❑	❑	German measles	❑	❑	numbness
❑	❑	asthma	❑	❑	headaches	❑	❑	polio
❑	❑	back pain	❑	❑	heart trouble	❑	❑	poor circulation
❑	❑	bladder trouble	❑	❑	reproductive disorders	❑	❑	hepatitis
❑	❑	bone fracture	❑	❑	high blood pressure	❑	❑	rheumatic fever
❑	❑	cancer	❑	❑	HIV/ARC	❑	❑	rheumatism
❑	❑	chest pain	❑	❑	kidney disorder	❑	❑	scarlet fever
❑	❑	concussion	❑	❑	bowel control loss	❑	❑	serious injury
❑	❑	convulsions	❑	❑	menstrual cramps	❑	❑	sinus trouble
❑	❑	diabetes	❑	❑	multiple sclerosis	❑	❑	tuberculosis
❑	❑	indigestion	❑	❑	muscular dystrophy	❑	❑	venereal disease

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No
Describe Condition____

Have you had any surgeries? ❑Yes ❑No
Surgery and Date: ____

Date of Last Physical Exam: ____

Please check any symptoms you may be experiencing **now**:
❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss/confusion ❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

Name:______________________________

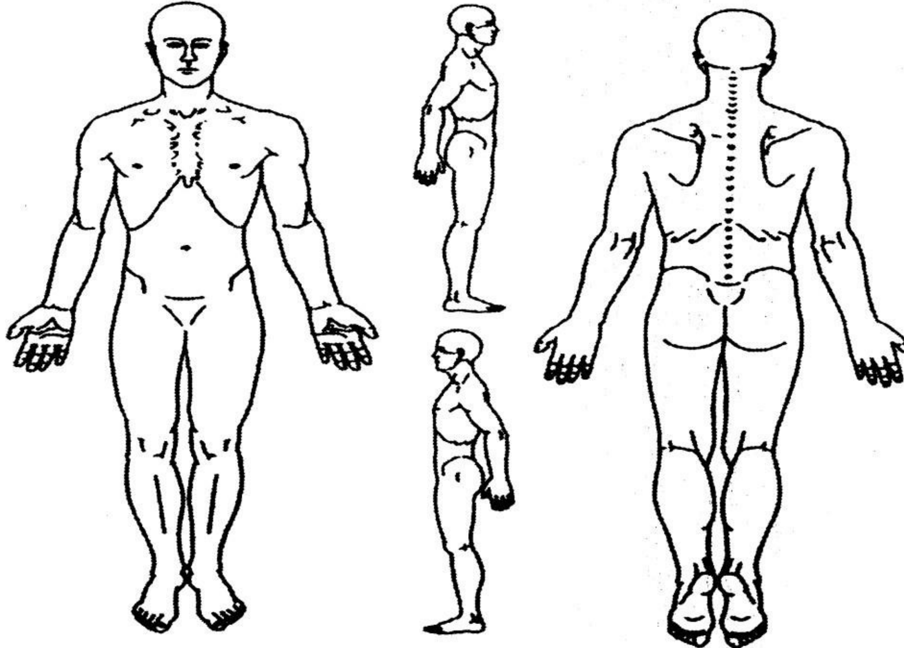
Date: ______________________________

Please describe major complaints:____

On the scale below, please circle the severity of your main complaint at its worst:

1	2	3	4	5	6	7	8	9	10

On the diagram below, please <u>circle</u> the areas where you are experiencing all of your present complaints:



Please check the following activities that **<u>aggravate</u>** your condition:

❑Bending ❑Coughing ❑Driving ❑Getting Up & Down ❑Increased activity in general ❑Lifting ❑Lying Down ❑Reaching ❑Sitting ❑Sneezing ❑Standing ❑Straining at stool ❑Turning head ❑Twisting injured area ❑Walking

Please check the following activities that **<u>relieve</u>** your condition:

❑Bending ❑Ice ❑Heat ❑Lifting ❑Lying down ❑Medication ❑Reaching ❑Resting ❑Sitting ❑Standing ❑Turning Head ❑Walking

Symptoms are worse in the: ❑Morning ❑Afternoon ❑Night

When and how did it occur? ____

Symptoms developed from: ❑Job related injury ❑Auto Accident ❑Illness ❑Unknown Cause ❑Gradual Onset

Date Occurred:______________________________________

Symptoms have persisted for #:_______Hour(s)_______Day(s)_______Week(s)_______Month(s)_______Year(s)

Symptoms/Complaints: ❑Come and go ❑Are constant

Have you ever had this before: ❑No ❑Yes When?______________________________________

Are you allergic to any medications? ❑No ❑Yes What kind?______________________________________

Are you taking any medications/supplements? ❑No ❑Yes What Kind?______________________________________

Are you pregnant? ❑No ❑Yes Date of last menstrual period:______________________________________

Patient's Signature:______________________________________Date:____________________________

Patient's Name ____
Patient's SS #______________________________Date of Birth ______________________________

THE PATIENT IDENTIFIED ABOVE AUTHORIZES THE TOUCH OF HEALTH CHIROPRACTIC TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to **Touch of Health** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards information about treatment alternatives or other health related information.

- If **Touch of Health** contacts me by phone; I give them permission to leave a phone message on my answering machine or voice mail.

- I give **Touch of Health** permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.

- By signing this form you are giving **Touch of Health** permission to use and disclose your Protected health information in accordance with the directives listed above.

EXPIRATION

The authorization shall expire on the following date:____.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **Touch of Health**. The written notice must contain the following information:
• Your name, Social Security number and date of birth;
• A clear statement of your intent to revoke this AUTHORIZATION;
• The date of your request; and
• Your signature.

The revocation is not effective until it is received by the Privacy Official.
This authorization is requested by **Touch of Health** for its own use/disclosure of PHI.
You have the right to refuse to sign this authorization. If you refuse to sign this authorization, **Touch of Health**, will not refuse to provide treatment.
You have the right to inspector copy the PHI to be used/disclosed.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU IF REQUESTED

Patient Name____

Signature________________________________**Date** ______________________________

Financial Policy

We are committed to providing you with the best care and are pleased to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please ask any questions you may have regarding our fees or your responsibility in complying with our financial policy and/or procedures. It is the policy of this office that all services rendered are charged directly to you, the patient, and ultimately you are responsible for all services. Including those not reimbursed by third party payers. Balances over sixty days and returned checks may be subject to additional charges.

- **Cash Patients**: Payment is due when services are rendered. We gladly accept Master Card, Visa, check orcash.

- **Insurance Patients Assignment of Insurance:** I hereby assign my rights and authorize and direct my insurance company, or other liable insurance company, or any other concerned party to make payment directly to The Touch of Health Chiropractic. I agree to notify Touch of Health Chiropractic of any change in insurance status. Touch of Health Chiropractic makes no representation as to whether or not the chiropractor participates in or accepts assignment of the patient's specific insurance or payer plan. Professional services are rendered and charged to your insurance on your behalf. Any services not covered by your insurance are ultimately your responsibility and may have to be paid by you at the time of service. If you fail to keep your scheduled appointments or if you discontinue care for any reason other than discharge by the doctor, the bill is due and payable by you in full, immediately, regardless of any insurance claim submitted. Our office accepts billing for Individual or Group Insurance policies, Personal Injury claims, and authorized Worker's Compensation. This assignment and direct payment authorization shall include any payments for services billed by The Touch of Health Chiropractic in connection with services rendered.

- **Collection/Attorney Fees**: Should I not pay this account as due; I will be liable for any court, attorney, or collection fees incurred by Touch of Health Chiropractic in collection of any balance due on the account for services rendered. I agree to pay all costs of a collection agency if necessary, to obtain payment in the event legal action should become necessary to collect an unpaid balance due for medicalservices.

- **Authorization to Process Drafts**: I agree that The Touch of Health Chiropractic shall be appointed as my agent to endorse drafts on any checks for payment of my bill for medical services rendered. If any insurance company should send a check directly to me that covers services rendered by The Touch of Health Chiropractic! I agree to deliver that check and any associated paperwork to this office within seven days ofreceipt.

- **Limited Release of Medical Information**: I authorize The Touch of Health Chiropractic to make inquires and to release any pertinent information to any insurance company, adjuster, or attorney to facilitate collection under these assignments.

- **Financial Agreement**: I understand, whether signing as patient or guardian, that the terms of payment for services rendered are due in full within thirty days of service. Balances remaining after insurance has paid are due within thirty days of the insurance payment unless other financial agreements have been made. I also understand that I am responsible for all charges incurred regardless of insurance or third-party liability. I will pay all services in full until The Touch of Health Chiropractic qualifies my coverage to determine the extent of benefits under my policy. I will pay the account in accordance with regular rates and terms of The Touch of Health Chiropractic. I agree that I may be responsible for 100% payment of the account. We reserve the right to bill any and all insurance carriers that may be responsible for providingcoverage.

- **Assignment of Cause of Action**: In the event that any insurance company or other third party obligated to make payment to me or to The Touch of Health Chiropractic for the charges made for the services, refuses to make such payment up demand, I hereby assign, transfer and convey to The Touch of Health Chiropractic any and all cause of action that might exist in my favor against any such company or person. I authorize The Touch of Health Chiropractic to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they seefit.

- **Referrals**: Touch of Health Chiropractic may refer me to Touch of Health Physical Therapy, Bel Air Chiropractic and/or North Valley Pain Management; however, I am free to choose any provider, regardless of my insurance benefits.

The undersigned certifies that he/she has read the foregoing has received a copy thereof and is the patient or guardian to the patient to execute the above and accept its terms.

Signature:____ **Date signed:**_______________________________

Printed Name:____ **Witness:** _________________________________