Adult Health Record

Today's Date:_____/_____/_____

Patient Name: _____

First **Middle** **Last**

ABOUT YOU

Address:_____ City:_____ State: _____ Zip:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

E-mail address:_____ Which hand do you write with?: R / L / Both

Age: _____ Date of Birth: ____/____/____ Gender: Male - Female Social Security #:_____/____/_____ Drivers Lic#:_____

Marital Status: S / M / D / W Spouse's Name:_____ Height:_____ Weight:_____lbs.

Your Occupation: (Job Title)_____

Employer's Name:_____ Work Phone: (_____)_____

Employers Address:_____ City:_____ Zip:_____

Payment will be made today by: ( ) Cash ( ) Check ( ) Credit Card Do you have Insurance ( ) No ( ) Yes (***See Insurance Info***)

EMERGENCY CONTACT

Spouse/ Significant Other/Parent (If Minor):_____ Phone: (_____)_____

HEALTH EXPERIENCE

Who or How Were You Referred to This Office:_____Who is responsible for your account?_____

Have you ever received Chiropractic Care? ( ) No ( ) Yes, was seen by Dr._____

Have you ever had any therapy/massage before? ( ) No ( ) Yes If yes, what type did you receive?_____

REASON FOR VISIT

Describe the reason for this visit:_____

_____

How did your discomfort begin?

( ) Auto ( ) Fall ( ) Home Injury ( ) Job ( ) Chronic Discomfort ( ) Other

Pain/Problem started on:_____ Any previous episodes of same condition?_____

Pain is: ( ) Sharp ( ) Achy ( ) Dull ( )Throbbing ( ) Constant ( ) Intermittent ( )Other:_____

What activities aggravate your condition/pain?_____

What activities lessen your condition/pain?_____

Is your condition worse during certain times of the day?_____

Is this condition interfering with ( ) Work ( ) Sleep ( ) Routine ( )Other:_____

Is your condition getting progressively worse? ( ) Yes ( ) No ( ) Other:_____

How are you feeling today? 1 2 3 4 5 6 7 8 9 10

(Circle Above, 1 = Low Pain 10 = Unbelievable Pain)

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons, some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

( ) **Relief care:** Symptomatic relief of pain or discomfort

( ) **Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.

( ) **Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

( ) ***I want the Doctor to select the type of care for my condition.***

HEALTH CONDITIONS

INSTRUCTIONS*: Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.*

( ) Abdominal pain	( ) Ankle swelling	( )Asthma	( )Back pain
( )Blood in urine	( )Blurred vision	( )Bright red stool	( )Cold extremities
( )Diabetes	( )Cold sweats	( )Constipation	( )Coughing
( )Dark black stool	( )Depression	( )Diarrhea	( )Difficulty breathing
( )Difficulty chewing	( )Difficulty swallowing	( )Dizziness	( )Double vision
( )Eyes sensitive to light	( )Excessive thirst	( )Excessive sweat	( )Extreme fatigue
( )Fainting	( )Flushed face	( )Headaches	( )Heart Disease
( )High Blood Pressure	( )Insomnia	( )Kidney Disease	( )Lightheaded
( )Loss of balance	( )Menstrual irregularity	( )Nausea	( )Neck pain
( )Numbness in extremities	( )Pain urinating	( )Pins/needles in extremities	( )Reduced appetite
( )Ringing in ears	( )Sinus problems	( )Tuberculosis	( )Ulcers/Colitis
( )Vomiting	( )Weight loss	( )Weight gain	

( )Other:_____

Do you have any forms of CANCER at this time? ( ) No ( ) Yes, if so what type?_____

Other Doctors Seen at this time: ( )MD ( )DC ( )DO ( )DDS Name(s):_____

Diagnosis: _____ Other Tests: ( )X-rays ( )MRI ( )Cat Scan ( )Blood Work ( )Urinalysis

Treatment: Medications: _____ Physiotherapy: _____ Other: _____

Results: _____ Length of time under care: _____Years _____Months - Frequency of Visits: _____

Have you ever had any other accidents, prior to this injury, if yes list dates: (including auto, sports, and injuries/accidents around the home or at work, also list any broken bones): _____

_____

List all surgeries and hospitalizations from birth up to today: _____

FOR WOMEN ONLY

Are you Pregnant? ( ) No ( ) Yes If yes, when is your due date?_____ Are you nursing? ( ) No ( ) Yes

Are you taking birth control?( ) No ( ) Yes Do you have painful periods? ( ) No ( ) Yes Do you have breast implants?( ) No ( ) Yes

MEDICATIONS/SUPPLEMENTS

Are you currently taking any medications either prescribed or over the counter: ( )Yes ( )No

( ) Blood Pressure Medicine ( ) Blood Thinners ( ) Cholesterol Medication ( ) Calcium/Magnesium ( ) Insulin
( ) Pain Killers (incl. Aspirin) ( )Vitamins ( ) Stimulants ( ) Muscle Relaxers
( ) Other(s)_____

( ) Allergies: ( )NONE ( )Aspirin ( )Tetanus Toxoid ( )Tetracycline ( )Codeine ( )Penicillin ( ) Latex ( )Dusts ( )Cats ( )Pollen
( ) Grass ( ) Foods ( )Other: _____

FAMILY HISTORY

	Age	Current state of health	Living/Deceased		Age	Current state of health	Living/Deceased
Mother:	_____	_____	_____	Father:	_____	_____	_____

Family History: List any conditions that your mother, father or any other relative has had which may include but is not limited to: Arthritis, Diabetes, Cancer, Heart Disease, Hypertension, Peptic Ulcer, Tuberculosis, Ankylosing Spondylitis, Multiple Sclerosis, Etc.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including and not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest.

By signing below, I agree to the above and allow the doctor and/or intern, affiliated with Hoops Chiropractic, to perform such. This consent will cover the entire course of my treatment.

*Patient Name:*_____ *Date:* _____

*Patient or Guardian Signature:*_____ *Date:*_____

AUTHORIZATION OF CARE/ASSIGNMENT OF BENEFITS

I hereby authorize the Doctor to work with my condition through the use of chiropractic adjustments, massage and other chiropractic procedures, including various modes of physiotherapy including massage therapy and diagnostic x-rays, on me (or on the named patient, for whom I am legally responsible) by the Doctor or Intern affiliated with Hoops Chiropractic. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance right and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare and necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. If a check goes to the Doctor's Office with my name on the check, I authorize Power of Attorney to sign my name so that the check can be deposited and credited to my account.

Patient or Guardian Signature: _____ *Date:*_____

NOTICE OF PRIVACY POLICY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE – "AOR"

What is HIPPS Administrative Simplification?

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care. In a nutshell, we are ordered to make sure all possible measures are in place in order to protect your medical information here in this office. Your medical file / information will not be given out to anyone without your consent. Other forms of protection are also implemented in order to protect your privacy as outlined in the **"NOTICE OF PRIVACY PRACTICES."**

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Hoops Chiropractic's "NOTICE OF PRIVACY PRACTICES," revision dated April 13, 2003.
As required by the Privacy Regulations, Hoops Chiropractic has explained the ***"NOTICE OF PRIVACY PRACTICES," to my satisfaction.***
As required by the Privacy Regulations, I am aware that Hoops Chiropractic has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information it maintains.

I acknowledge that I received a copy of Hoops Chiropractic ***"NOTICE OF PRIVACY PRACTICES," revision dated April 13, 2003.***

*Patient Name (Print):*_____

*Patient or Guardian Signature:*_____ *Date:*_____

*Signed Form Received by:*_____
*If patient refuses to sign, place X here:*_____

HOOPS CHIROPRACTIC FEE SCHEDULE

Welcome to our office! The information below regarding our fees is provided to you to make you aware that our fees are different if you are paying cash or are requesting to use your personal insurance for coverage of services.

CASH: Currently, our cash rate for a Chiropractic examination is $70 and the Adjustment is $45. Please expect to pay $115 on your first visit to our office, unless you are utilizing an applied discount from a promotional option. Additional charges may apply for physiotherapies, if needed, which include ultrasound, heat, massage, muscle stim, etc. These fees are also called point-of-service fees as they are paid at the time services are rendered. Understand also that this is a *discounted* fee from our regular insurance-based fees which range from $95-$170.00 per visit (dependent on therapies performed including ultrasound, heat, massage, muscle stim, etc.)
If, at any time, you have any other coverages either through insurance or an auto accident, please notify our office immediately so that we can make efforts to Change your fee status accordingly.

I have read and understand the fees charged at Hoops Chiropractic.

Patient Signature_____ Date:_____

INSURANCE INFORMATION

We will need to make a photocopy of your *Insurance Card -&- Driver's License*.

If you are not the primary insured or the policy holder, then we will need the following information.

Name of Insured:_____ S.S. # of Insured:_____-_____-_____

Insured's Date of Birth: _____/_____/_____ Insured Employers Name:_____

INSURANCE: If your health insurance offers coverage, we will do our best to verify your benefits and bill it in accordance with any contractual guidelines, usually these chargers range from $65-$250.00 dependent on therapies you receive. All billing is done as a courtesy to you, to help offset your cost; however, there may be times when we are mis-quoted information or payment is not made as described by your insurance. These additional amounts are your responsibility and we will do our best to keep you apprised of any information regarding your benefits if they should change. If your health coverage or health condition changes, you must notify the Doctor immediately. You are also responsible for payment of any deductibles, co-pays, and co-insurance amounts not covered by your insurance. IN THE EVENT THAT YOUR INSURANCE DOES NOT COVER A CHARGED FEE, HOOPS CHIROPRACTIC AGREES TO NOT CHARGE YOU MORE THAN THE AGREED AND POSTED CASH RATE FOR THAT SURVICE.

All fees charged at Hoops Chiropractic are reasonable and in keeping with the industry standards. We use the insurance fee schedule as a guideline for setting our fees, as is also typically done in the chiropractic industry.

Patient Billing Acknowledgement Form
MAINTENANCE/ELECTIVE CARE NOTIFICATION

Under your health plan, you are financially responsible for co-payments, co-insurance, or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or **maintenance.**

Maintenance/elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary (pain does not automatically prove medical necessity). You may also choose to receive maintenance care once maximum benefit from treatment has been reached.

Examples of maintenance care include: Treatment that seeks to PREVENT disease or PROMOTE health and enhance quality of life as well as MAINTAIN or PREVENT DERERIORATION of a *chronic* condition. Treatment should be actively helping a person to improve to be considered medically necessary. When care becomes supportive rather than corrective, treatment is considered to be maintenance. Treatment will also be considered maintenance when a patient has reached maximum therapeutic benefit (MTB) but continues treatment. Most treatments reach a point where no further significant improvement can be expected and this is called MTB. MTB can be reached when complaints either fully resolve or when pain and/or disability persist – even with ongoing treatment.

Most healthcare benefit certificates do not include coverage for treatment that is not resulting in a reasonable expectation of further improvement to a patient's condition.

If during the course of maintenance/elective care you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered maintenance/elective and may then be covered by your health plan.

Unfortunately, your insurance has cracked down on treatment that they deem not medically necessary. We are forced to administer pain questionnaires regularly and preform re-exams to justify your care, by actively showing a positive response to your treatment here. If, when your condition has stabilized and you are no longer making significant improvements, we will have no choice but to transition you to a cash basis. If your condition changes, flares, or you have a new condition, we can reinstate billing your health insurance.

ASH (American Specialty Health) List of services to be paid for by member:

-	Massage	$65/hr (unless promo is applied)
-	Heat/E-stim	$5 each
-	Ultrasound/Diathermy	$15 each
-	Sports taping	$5 per body region
-	Graston	$40 per body region

I understand the above conditions for billing my health insurance. I understand that when my care is deemed for maintenance that I will be financially responsible for my care. If my condition changes or I have a new condition, I will inform the staff immediately to see if I am eligible for coverage under my health plan.

_____ _____

Patient Name (Print) Date

_____

Patients Signature