Childs Family Chiropractic-Chiropractic Case History/Patient Information

Date: _____

Name: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____ Carrier: _____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ Fax: _____

Age: _____ Birth Date: _____ Marital Status: M S W D Race/ethnicity: _____

Occupation: _____ Employer: _____

Employer Address: _____ Office Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

How many children? _____ Names & Ages of Children: _____

Emergency contact: _____ Phone: _____

How were you referred to our office: _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ____yes ____no

INSURANCE INFORMATION:

Name of Insurance: _____

Insured's ID: _____ Group #: _____

Name of Policy Holder: _____ Policy Holders Date of Birth: _____

Relationship to Policy Holder: _____

HISTORY OF PRESENT ILLNESS: (Fill out Completely)

Chief Complaint-purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto: ____ Work: ____ Other: _____

Have you ever had the same or a similar condition? ____Yes ____ No
If YES, Please describe and dates:_____

Days lost from work: _____ Date of last Physical examination: _____
How Frequent is the condition? _____ Constant _____Intermittent _____ Night Only
How long does it last? _____ All Day/Night _____Few Hours _____ Minutes

Are there any other conditions or symptoms that may be related to your major symptoms? ____yes ____no

If yes, please describe: _____

_____

What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___ Lifting __ Twisting ___ Other_____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ___ yes ___ no ___uncertain

PAST MEDICAL HISTORY:
Have you ever been diagnosed as having or have suffered from? (**Place a check mark by all conditions that apply to you**)

__Broken/Fractured Bones
__Circulatory Problem
__Rheumatoid Arthritis
__Seizures/Convulsions
__A Congenital Disease
__Depression
__Kidney Disease
__Lung Disease
__Osteoarthritis
__Epilepsy
__Pace Maker
__Strokes
__Cancer
__Diabetes
__Liver Disease
__Eating Disorder__Ulcers
__Alcoholism
__Drug Addiction
__HIV Positive
__Gall Bladder
__Tuberculosis
__Mental Illness
__Coughing Blood
__High/Low Blood Pressure
__Excessive Bleeding
__Ruptures
__Asthma
__Heart Disease

Do you have a history of stroke or Hypertension? ____ Yes ___No

Have you had any major illnesses, injuries, falls, auto accidents or surgeries (Women, please include information about any pregnancies/deliveries)

_____

_____

_____

Have you been treated for any health condition by a physician in the last year? ____yes ____no
If yes, please describe:_____

What medications are you taking:_____

_____

Do you have any allergies to any medications, nutritional products or food? ___yes ___no
If yes, please describe: _____

Do you have any allergies of any kind? ___ yes ____ no
If yes, please describe: _____

Please list any other health problems you have, no matter how insignificant they may be: _____
_____

_____

_____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages? ___ yes ___ no If yes, how much per week? _____

Do you use tobacco products? ___yes ___no Packs per day: _____ Chew: _____

Do you take vitamin supplements? __ yes __ no If yes, please list: _____

Do you consume caffeine? __ yes ___ no If yes, how much per day: _____

Do you exercise? ___ yes ____ no If yes, how often and type of exercise: _____

What are your hobbies:_____

Percentages of time during the day, either at home or work, do you spend:

Lifting:____ Sitting:_____ Standing:_____ Bending:_____ Walking_____ Working on a computer:_____ twisting_____

Other: _____

FAMILY HISTORY:

Parents: Father: ___ Living. Current age: ____. ___ Deceased. Cause of death and age at time of death: _____

Mother: ____Living. Current age: ____. ___ Deceased. Cause of death and age at time of death: _____

Check if applicable:

_____ As an adopted child, little is known of birth parents or family

Do you have any family members who suffer from the same condition you do? ____ yes ____no

If yes, please list:_____

FAMILY DISEASES: (Check if applicable and **indicate whether family member** is **F**ather, **M**other, **S**ister, **B**rother)

_____Tuberculosis	_____Cancer	_____Mental Illness	_____Stroke
_____Diabetes	_____Asthma	_____Heart Disease	_____Arthritis
_____Kidney Disease	_____Lung Disease	_____Liver Disease	

Other: _____

Patient Signature: _____ Date: _____

Guardian's Signature:_____ Date: _____
Authorizing care

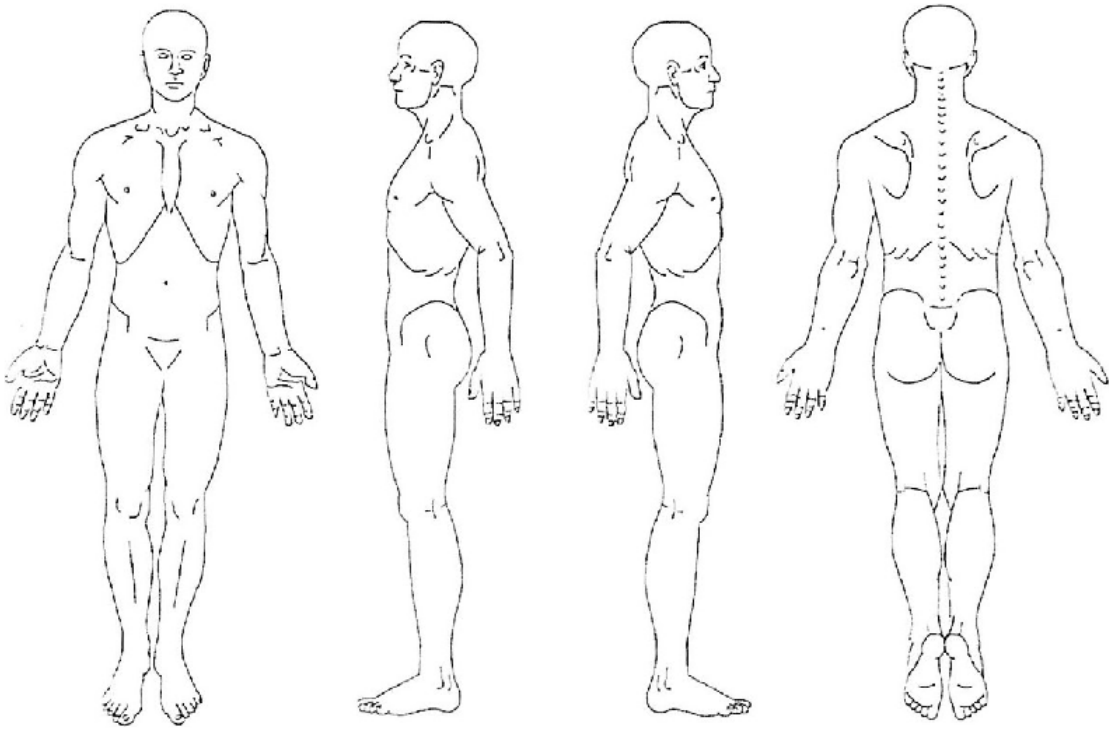
CHUCK CHILDS, D.C.
CHILDS FAMILY CHIROPRACITC
1330North Interstate Drive Norman. OK 73072 • (405) 366-9355

PAIN DRAWING

Name_____Date_____

Using the following descriptive symbols, draw the location of your pain on body outlines below. In addition. mark the level of your pain on the pain line at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
^^^^^^	======	OOOO	. . . . .	//////////	XXX
^^^^^^^	======				



No Pain 1. _____ 10 Possible Worst Pain

Please make a slash through this line to indicate the level of your pain.

Patient Signature

_____

Childs Chiropractic Wellness Center

Financial Policy

Chiropractic care is covered under many insurance policies. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this financial policy. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE:

We request that 100% of the first and second visit be covered at the time of that visit. On subsequent visits payment may be made in advance, or at the end of the week if you sign a credit guarantee form. We are happy to accept your check, cash, or any valid credit card._____

GROUP OR INDIVIDAUL INSURANCE:

When possible, we will call your insurance company to verify benefits and eligibility on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment for non-covered services, deductibles, and co-pay, will be due at the time of service. _____

- **ON THE JOB INJURY (WORKER'S COMPENSATION):**

If you are injured on the job, your care should be paid for under your employer's worker's compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 90 days, or if you suspend or terminate your care, any fee for services are due immediately._____

PERSONAL INJURY OR AUTOMOBILE ACCIDENT:

We will file your claim with the appropriate insurance carrier (your health insurance and/or auto med-pay), and third party carrier (the other person's insurance) as you are treated, and file a Physician's Lien to assure payment. The third party carrier will not pay until settlement is reached. To prevent your premium from being affected due to a claim being made, even if you were not at fault, you may need to inform the third party insurance carrier to subrogate upon settlement of your claim; any balance will be forwarded to you. You agree not to allow your attorney to reduce our fees for their/your profit. When released, a 90-day time period is allowed for settlement. If you have not settled with the third party carrier within this time, or if you have suspended/treatment care without your doctor's approval, the balance of your account is due immediately._____

I have read and understand the financial policy of Childs Chiropractic Wellness Center. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Dr. Childs and my insurance company. I request that Childs Chiropractic Wellness Center prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days of if I suspend or terminate my schedule of care as prescribed by Dr. Childs, all fees are due and payable

immediately. Any account that goes past due 60 days or greater will be charged 21% APR, in addition to collection fees. There will be a $29.00 fee for any returned check.

Patient signature (guardian if patient is a minor) Date

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of heath care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke.

Prior to receiving chiropractic care in this Chiropractic office, a health and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

[redacted]

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_____ _____

Patient Name (printed) Relationship to patient

_____ _____

Patient or legal Guardian Signature Date

_____ _____

Witness Signature (office staff) Date

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent For Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance
Manual, State law and Federal Law.

Date this _____ day of _____, 20_____

By _____
Patient's Signature

If patient is a minor or under guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

Name: _____
Chart Number: _____

CHILDS CHIROPRACTIC WELLNESS CENTER
Dr. Chuck Childs
1330 N. Interstate Dr.
Norman, OK 73022
(405-366-9355)

CREDIT GUARANTEE

The credit on file policy is a convenient method to pay for the portion of services that are deemed patient's responsibility, such as copay, deductible and co-insurance.

Co-pays: Co-pays are due at time of the office visit. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to 60 days for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you leave a credit card to guarantee payment.

Outstanding balance: If your insurance provider has paid their portion of your bill and there is an outstanding balance owed, we will reach out to you by phone or mail. After 30 days the credit/debit card on file will be automatically charged for any outstanding balance. A copy of the charge will be mailed to you. In the case when a debit/credit card has reached its maximum, we will reach out to you. You will have an additional 30 days to arrange payment before the bill is subject to addition collections activity.

CANCELLATION AND MISSED APPOINTMENTS

In order to be respectful of the needs of other patients please be courteous and call us promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance**. If 24-hour notice is not given, you will be charged $25 PER MISSED/CANCELLED APPOINTMENT.**

CREDIT CARD: ____AMEX ____VISA ____MC ____DISCOVER

CARDHOLDER NAME: _____

CARD #_____ EXP. DATE_____

BILLING ZIP CODE: _____ V CODE: _____ BILLING AMOUT: $_____

I AGREE TO THE ABOVE TERMS AND AUTHORIZE YOU TO BILL THE CHARGE CARD. I UNDERSTAND THAT SHOULD PAYMENT NOT BE RECEIVED WITHIN 60 DAYS AFTER SUBMISSION OF MY CLAIM, OR SHOULD I TERMINATE CARE BEFORE DISMISSED BY YOUR PHYSICIAN, I WILL BE CHARGED THE AMOUNT DUE. I ALSO UNDERSTAND THAT BY NOT AGREEING TO THIS FINANCIAL POLICY CHILDS FAMILY CHIROPRACTIC RESERVES THE RIGHT TO REFUSE TREATMENT.

____ ______________________

SIGNATURE DATE