Patient File # _____

WELCOME

Tone

ABOUT YOU

Today's Date: ____ /_____/_____

Your Name: _____ **Male** **Female**
LAST FIRST MI

Birth date: ____/_____/_____ **Age:** _____ **Social Security #:** _____

Mailing Address: _____

City_____ State_____ Zip_____

Home Phone #: _____

Work Phone #: _____ Ext: _____ **Mobile #:** _____

E-Mail Address: _____@_____

Whom may we thank for your referral?_____

Employer: _____ **Occupation:** _____

Employer's Address: _____

City_____ State_____ Zip_____

Marital Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? **Yes** **No** How Many? _____

WINDWARD CHIROPRACTIC CENTER
Optimum Healthcare Through Chiropractic

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INSURANCE INFORMATION

Name of Insurance: _____

Insured ID #: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ Relation: _____

Date of Birth: _____/_____/_____ **Insured's Employer:** _____

*** Please inform front desk of 2nd Insurance source**

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ACCOUNT INFORMATION

Person ultimately responsible for account

Name: _____ **Relation:** _____

Billing Address: _____

City_____ State _____ Zip _____

Social Security #: _____

Drivers License #:_____

Daytime Phone #: (_____)_____

Payment Method: Cash Check Credit Card

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office). _____

Initials

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REASON FOR VISIT

The reason for today's visit: Emergency New Injury Old injury Chronic Pain Wellness

Are you in pain: Yes No **Rate your pain with the following scale:**

discomfort ——— intense
1 2 3 4 5 6 7 8 9 10

Did your injury occur during:

Work Sports/play Auto Accident Routine/Household activity Other

When did your condition/accident occur? _____/_____/_____

Where did your injury occur? _____

Please explain what happened:_____

_____

Is this condition getting worse? Yes No Constant Comes and Goes

Is your condition interfering with your: Work Sleep Daily routine?

If so, please explain: _____

_____

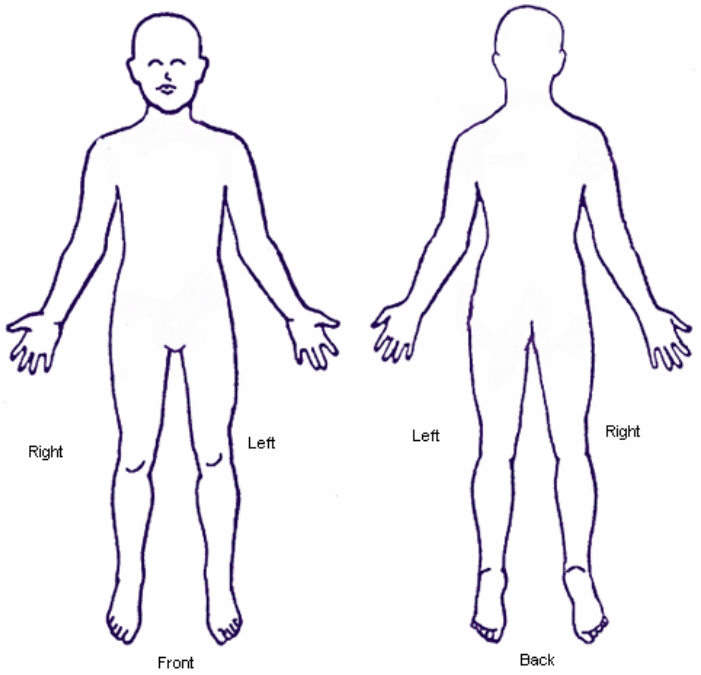
Has this or something similar happened in the past? Yes No

If so, please explain: _____

_____

Using the adjacent body chart, please circle and label all affected areas using the following symbols:

XXXX (NUMBNESS)
^^^^ (PINS AND NEEDLES)
VVVV (BURNING)
ZZZZ (ACHING)
OOOO (STABBING)



Have you been treated by a Medical Physician for this condition? Yes No

If so, where? _____

_____

Have you ever been treated by a Chiropractor?

Yes No

Clinic or Doctor's name: _____

Clinic phone #:_____

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HEALTH HISTORY

Are you taking any of the following medications? Nerve pills Pain Killers (including aspirin)

Muscle relaxers Blood Thinners Tranquilizers Insulin Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Heart Attack/Stroke	Heart Surg./Pacemaker	Heart Murmur	Artificial Valves
Mitral Valve Prolapse	Alcohol/Drug Abuse	Venereal Disease	Hepatitis
Congenital Heart Defect	HIV+/AIDS	Cancer	Glaucoma
High/Low Blood Pressure	Psychiatric Problems	Anemia/Diabetes	Shingles
Neck Pain	Rheumatic Fever	Ulcers/Colitis	Kidney Problems
Severe/Frequent Headaches	Emphysema/Asthma	Sinus Problems	Tuberculosis
Fainting/Seizures/Epilepsy	Difficulty Breathing	Chemotherapy	Arthritis
Artificial Bones/Joints/Implants	Lower Back Problems	Middle Back Problems	
Shoulder Problems L R	Hip/Leg Pain L R	Arm/Hand Problems L R	

Please list any surgeries with dates and/or other serious medical condition(s) not listed above: _____

_____

List any past serious accidents with dates: _____

_____

Please list anything that you may be allergic to: _____

_____

Family Health History: _____

_____

Do you take Supplements or Vitamins? Yes No **Do you exercise?** Yes _____hours per week No

Do you smoke? Yes How much? _____ How long? _____ No

Are you wearing: Shoe lifts Inner soles Arch Supports

Are you dieting? Yes Since: _____/_____/_____ No

For women: Are you using Birth Control? Yes No Type or name of prescription: _____

Are you Nursing? Yes No Are you Pregnant? Yes No If so, due date : _____

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IN EVENT OF EMERGENCY

Whom should we contact? _____ **Relation:** _____

Contact Phone #: _____

- *We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.*

- *Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.*

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ _____

Patient Name Printed Date

_____ Adult Patient Parent or Guardian Spouse

Patient Signature

_____ _____

Authorized Provider Representative Personal Representative Printed

_____

Personal Representative Signature

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PATIENT POLICY

Patient-Doctor Agreement: The purpose of this agreement is to allow us to better serve you and to get the best results possible in the shortest amount of time. It is our experience that those patients who adhere to the following agreement get the best results.

Canceling or Changing Appointments: The doctor has set up a specific regimen of treatment for you. A certain number of treatments in a set amount of time is required for you to get the results we both desire. Thus, if you need to change the time of your appointment, plan to come at another time the same day. Please advise us of these changes within two hours prior to your appointment. If the same day is not possible, be sure to make up the missed appointment on the next day. Please advise our office of these schedule changes within 24 hours prior to your appointment. Please remember that the doctor cannot help you if you are not following the required recommendations and/or are not keeping your recommended scheduled treatments. All cancellations or appointments rescheduled to a different day with less than a 24 hour notice will be subject to a $50.00 missed appointment fee.

*The same missed appointment requirements also apply to massage appointments, but they have a different and separate fee schedule. A missed 30 minute massage carries a $40.00 fee and a missed 60 minute massage carries a $75.00 fee.

Office hours: Monday through Friday ***10am-6pm*** (no appointments scheduled from 1pm-3pm)
Saturday and Sunday ***Closed***
Emergency appointments are available. Please call 678.908.5850 for after hour emergencies

Upsets: We are here to serve you. Please speak with your doctor or the management about any upsetting matter (i.e. long waits, staff insensitivity, confusion about treatment, etc.) We see your comments as an opportunity to improve our service.

Getting Well: The most important thing of all is your PERSONAL COMMITMENT TO GET WELL so that you can enjoy your newfound health.

I have read and understand the Patient Policy.

Signature _____

Date _____

AUTHORIZATIONS

Appointment Reminders & Information: Your doctor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information to leave messages on your answering machine or with individuals at your home or place of employment.

Products And Services: From time to time our practice would like to make you aware of products or services that you may have an interest in purchasing. This marketing will be done by our internal staff only. We do not share patient information with any outside marketing organization. Your doctor and members of the practice staff may need to use your health information including your name, address, phone number, and your clinical records for the purpose of marketing products and services from **Windward Chiropractic** to you. We are specifically requesting authorization to market the following products and/or services to you:

- ❑ *We thank our patients for referrals by listing their names in our office.*
- ❑ *We run patient recall programs to remind them of the value of chiropractic care.*
- ❑ *We post pictures of our children through the office.*
- ❑ *We send birthday cards to our patients in which we offer complimentary services*
- ❑ *We send our patients newsletters in which we feature products, services or promotions available in our practice.*
- ❑ *We participate in fund raising activities for charitable donations.*

You may restrict the individuals or organization to which your health care information is released, or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, marketing purposes, or other health related information at any time.

This notice is effective as of _____.
This authorization will expire seven (7) years after the date on which you last received services from us.

I authorize Windward Chiropractic to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____
Patient Name Printed Date

_____ _____
Patient Signature Authorized Provider Representative

_____ _____
Personal Representative Printed Personal Representative Signature

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CONSENT POLICY FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge:

We are very concerned with protecting your privacy. While the law requires us to allow you access to our privacy notice, please understand that we have, and always will, respect the privacy of your health.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer to them for the diagnosis, assessment, or treatment or your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

A copy of our privacy notice is available upon request and describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures:

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use of disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to Revoke your authorization:

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we received your request. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of your privacy notice upon my request.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Authorized Provider Representative

_____ _____

Personal Representative Printed Personal Representative Signature