Chiropractic Health Centers

Jason McDonald DC BCAO

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Charlotte, NC 28277

(704) 271-3160
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Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Cell Phone Carrier: _____ Preferred Way to Contact You: ☐ Text ☐ Email ☐ Phone Home/Cell

Email Address: _____ _____Occupation: _____

Date of Birth: _____ Social Security #: _____-_____-_____ Gender: Male - Female

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other _____

Who may we thank for referring you to our clinic? _____

List any **Allergies**:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs ☐ Latex ☐ Molds ☐ Penicillin ☐ Ragweed/Pollen

☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye ☐ Other: _____

Medicine Allergies :_____

List any **Surgeries**:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist ☐ Other: _____

List **ALL Past Medical History** conditions:

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain ☐ Depression

☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting ☐ Fatigue ☐ Foot Pain

☐ Genetic Spinal Condition ☐ Hand Pain ☐ Headaches ☐ Hearing Problems ☐ Hepatitis ☐ High Blood Pressure

☐ Hip Pain ☐ HIV ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain ☐ Menstrual Problems ☐ Mid-Back Pain

☐ Minor Heart Problem ☐ Multiple Sclerosis ☐ Neck Pain ☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's

☐ Polio ☐ Prostate Problems ☐ Shoulder Pain ☐ Significant Weight Change ☐ Spinal Cord Injury ☐ Sprain/Strain

☐ Stroke/Heart Attack ☐ Other: _____

List any Medications/Supplements/Herbs: **Why**:

_____

_____

_____

List your **Family History**:

□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression □ Diabetes □ Epilepsy □ Genetic Spinal Condition

□ High Blood Pressure □ Heart Problems □ Multiple Sclerosis □ Neurological Problems □ Parkinson's □ Polio

□ Prostate Problems □ Stroke/Heart Attack □ Please list all family members who had/has any of the problems above:

Example: Grandmother – High blood pressure

_____

_____

_____

Have you had any auto or other accidents? □ No □ Yes

Describe: _____

Date of last physical examination: _____

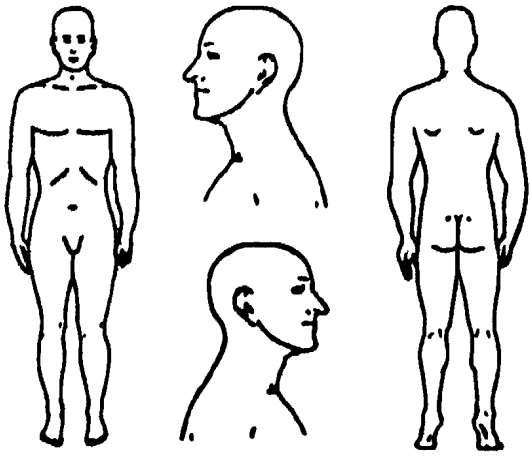
Do you smoke?: □ No □ Yes ☐ Daily ☐ Occasionally ☐ Previous

Do you drink alcohol? □ No □ Yes - how much per day? _____

Do you drink caffeine? □ No □ Yes - how much per day? _____

Do you exercise? □ No □ Yes (what forms and how often): _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

□ Become pain free
□ Restorative Care
□ Resume normal activity level
□ Maintenance Care
□ Nutrition/Wellness Care

1. What is your **Major** complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)?

_____

_____

_____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

Explain:_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

2. What is your **SECOND** complaint? _____ Date problem began?_____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

3. Do you have **another** complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE□ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Have you ever had Chiropractic care…..NO YES
When?_____ Why?_____
Where?_____
Were X-rays taken in the last 12 months? NO YES
Date of last adjustment?_____

Nutrition: Do you have any of the following:

_____Anxiety_____Depression_____Heartburn_____Indigestion_____Irregular Bowel Movements

_____Stress

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the physician.

I have read the foregoing and understand it.

_____ _____

Patient's Signature Date

X-RAY QUESTIONNAIRE **FOR WOMEN ONLY**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

- There is a possibility that I may be pregnant at this time.
- Yes, I am definitely pregnant.
- No, I am definitely not pregnant at this time.
- I request that x-ray films not be taken because _____

_____

_____

Date of last menstrual period: _____

_____ _____

Patient's Signature Date

Financial Policies

1. Payment for services is expected at the time services are rendered.
2. A patient's insurance will be verified, however verification is not a guarantee of payment. The patient will be responsible for any charges not covered by the insurance.
3. If a charge is determined noncovered by the insurance carrier through, payment is expected at the time service is rendered.
4. We will bill the patient's insurance 2 times within a 45 day period. If no response from the insurance, the patient will be responsible for the balance.
5. If the doctors are out-of-network with the patient's insurance, we expect payment in full at the time of service unless other arrangements have been made.
6. We will bill the patient for any unpaid patient portion after the insurance has made final payment. The patient will receive a minimum of three statements requesting payment. After a final notice is sent, the account will be turned to a bad debt collection agency.
7. The bad debt collection agency will report any unpaid balance to the credit bureau.
8. If we need to hire an attorney to recover any unpaid balances, all legal fees associated with such balance will be your responsibility.
9. A charge of $25 will be made for the copying of any patient medical records.

Personal Injury Financial Policies

1. If the patient has medpay, we will bill the patients medpay first. If you do not have medpay, we will bill the responsible parties insurance. If the insurance has not paid after 120 days of being released, the bill is the patients responsbility.
2. If the patient has an attorney, we will bill the attorney at the time the treatment plan is completed and the patient is released from care.
3. Payment for any services, supplies, or equipment utilized by the patient which are not a result of the accident will be expected at the time the service, supply or equipment are rendered/ordered.
4. If a patient receives payment from a medpay carrier or attorney for services rendered at our facility without payment of our bill, the account will be turned to a collection agency within 30 days upon notification of the payout.
5. The State of North Carolina has a 3 year statute of limitations with all auto accidents beginning on the date of accident. If the balance has not been paid by the end of those 3 years, balance is then the patient's responsibility and is due immediately.

Medicare Recipient Financial Policies

1. Medicare does not pay for maintenance visits. Once a patient's treatments have been determined to be maintenance, the patient will be responsible for the entire visit balance, at the approved Medicare rates.
2. Medicare will pay for the chiropractic adjustment only. Any other services are not covered by Medicare and payment will be expected at the time of service.

I have read and understand all financial policies with Chiropractic Health Centers.

Patient Signature:_____

Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a Notice of Privacy Practices for Protected Health Information Practices that provides a more complete description of information uses and discloses. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent.
The right to object to the use of my health information for directory purposes, and
The right to request restrictions as to how my health information my be used or disclosed to carry out treatment, payment, or health care operations

_____ _____
Patient Signature/ Parent or Guardian Signature Date

_____ _____
Witness Date