CHIROPRACTIC PATIENT UPDATE

Please complete Parts A & C in all cases. Part B should be completed only if the information has changed since you were last in our office.

Thank You!

PART A

Name: _____ Phone: _____

E-mail address: _____ Fax # _____ Cell Phone _____

Address: _____

Purpose of this appointment: _____

Is this the same problem you were originally under care for? ( ) Yes ( ) No

If yes, are there any additional symptoms? _____

Other doctors seen for this condition: _____

What medications or drugs are you taking? _____

PART B

Occupation: _____ Employer: _____

Employer's address: _____ Work Phone: _____

Spouse: _____ Spouse's Employer: _____

PART C

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that any unpaid balance after 30 days of invoice will be subject to simple interest at the rate of 7% per year, until balance is paid in full. In addition, delinquent accounts will be charged a rebilling fee of $15 per month. If we choose not to charge the interest or rebilling fee for one or more months, that does not prevent us from charging them in any other month.

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and other diagnostic methods as needed to treat my health care condition. I give authority for these procedures to be performed.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Date Signed: _____ Signature: _____

Health Insurance Coverage ( ) Yes ( ) No

Company: _____

CURRENT COMPLAINT HISTORY
(PATIENT)

Patient Name: _____ **Date:** _____

Please check all boxes that apply to your condition **and fill in the spaces that describe your present complaint(s). Also, the information you provide concerning past symptoms will help in assisting the doctor to better understand your present complaints and total health picture.**

Please list your present complaint(s) and mark your level of pain today for each complaint – If you have more than one area of complaint, list them in order of most severe to least severe.

1. _____ **Duration – (How Long / Date):** _____ **# of Previous Episodes:** _____
   (*Please circle one.*) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)
2. _____ **Duration – (How Long / Date):** _____ **# of Previous Episodes:** _____
   (*Please circle one.*) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)
3. _____ **Duration – (How Long / Date):** _____ **# of Previous Episodes:** _____
   (*Please circle one.*) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Has anyone treated you for this episode? ❑Yes ❑No If yes, by whom? _____

How did your **symptoms begin?**

❑Immediately after a specific incident ❑After multiple Incidents ❑Gradually developed over time ❑Other _____

What makes your **symptoms better?**

❑Nothing ❑Lying down ❑Standing ❑Sitting ❑Movement/Exercise ❑Other _____

What makes your **symptoms worse?**

❑Nothing ❑Lying down ❑Standing ❑Sitting ❑Movement/Exercise ❑Other _____

Are your **symptoms?**

❑Decreasing ❑Increasing
❑Not Changing ❑Other _____

Description of pain or symptoms:

❑Sharp ❑Shooting
❑Dull ❑Burning
❑Ache ❑Numb/Tingling
❑Weakness ❑Stiff
❑Throbbing ❑Other_____

Does your pain **move** or **radiate?**

❑Yes ❑No Where _____

Check the best and worse **times of the day** for your pain:

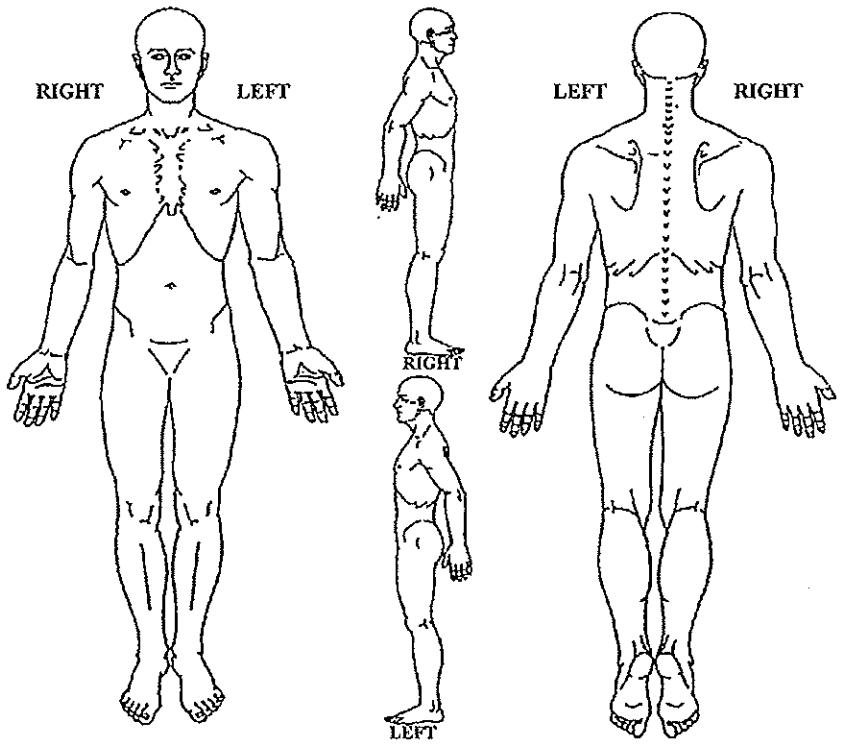
Best	Worst
❑First Awake	❑First Awake
❑Morning	❑Morning
❑Afternoon	❑Afternoon
❑Evening	❑Evening
❑Nighttime	❑Nighttime
❑Other	❑Other

Frequency of pain or symptoms:

❑Constant (76 – 100%)
❑Frequent (51 – 75%)
❑Occasional (26 – 50%)
❑Intermittent (25% or less)

SHOW US YOUR PAIN
USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SYMPTOMS TODAY

KEY: A = ACHE B = BURNING N = NUMBNESS P = PINS & NEEDLES
S = STABBING X = STIFFNESS T = THROBBING O = OTHER



How many days out of **an average week** are you in **pain?** (Please circle one.) 1 2 3 4 5 6 7

How much time during the **day** are you in **pain?**

❑less than 1 hour ❑1 to 6 hours ❑6 to 12 hours ❑12 to 18 hours ❑18 to 24 hours ❑24 hours

Patient's/Guardian's Signature: _____ **Date:** _____

Discover Chiropractic Center, PC 6740 Cascade Road SE Suite 6 Grand Rapids, MI 49546 Phone: (616) 956-1112 Fax: (616) 956-6265 Web: www.dchiro.com

DISCOVER CHIROPRACTIC CENTER, PC
6740 Cascade Road Ste. 6
Grand Rapids, MI. 49546
P: 616.956.1112

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Discover Chiropractic, or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date