Chiropractic Case History/Patient Information

Date:_____

Name:_____ Birth Date:_____ SS#: _____ - _____ - _____

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

E-mail address: _____May we send appointment reminders to this email?: Yes/No

Cell Phone: _____Cell phone carrier: _____ (in order to send text reminders)

Home Phone: _____ Race:_ _____ Marital: M S W D

Occupation:_____

Spouse's Name (only required if this is your insurance policy holder):_____

How were you referred to our office?_____

Family Medical Doctor (first and last name): _____

HISTORY OF PRESENT ILLNESS:

Chief Complaint (reason for 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 answered yes, when was this and describe the circumstances: _____

Any days lost from work?:_____

Date of last physical examination:_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Please check)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder
__Circulatory Problems	__Epilepsy	__Alcoholism
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction
__Seizures/Convulsions	__Strokes	__HIV Positive
__A Congenital Disease	__Cancer	__Gall Bladder
__Excessive Bleeding	__Ruptures	__Depression
__High/Low Blood Pressure	__Coughing Blood	__Ulcers

Have you had any major illnesses, injuries, falls, auto accidents, hospitalizations or surgeries? Women, please include information about childbirth (include dates): _____

_____

Are you currently being treated for any chronic health conditions? ____ Yes ____ No

If yes,describe:_____

What medications (including vitamins) are you currently taking?_____

_____

Do you have any allergies to any medications? ___Yes ___ No

If yes, describe:_____

Do you have any allergies of any kind (i.e. seasonal, latex, etc.)? __ Yes __ No

If yes, describe:_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?___ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day?: _____
Do you consume caffeine?____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
What are your hobbies?_____

FAMILY HISTORY:

Parents:
Father: living___ deceased____ (check one) Current age if still living:_____
Cause of death and age at death if deceased?:_____

Mother: living___ deceased____ (check one) Current age if still living:_____
Cause of death and age at death if deceased?:_____

Check if applicable: ____ As an adopted child, little is known of birth parents or family.

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

Tuberculosis____	Cancer____	Mental Illness____
Diabetes ____	Asthma____	Heart Disease ____
Stroke ____	Kidney Disease____	Lung Disease____
Arthritis_____	Liver Disease ____	High Blood Pressure ____

Other _____

Please check any and all insurance coverage that may be applicable in this case**:**

___ Major Medical ___ Worker's Compensation ___ Medicare ___ Auto Accident
___ Medical Savings Account & Flex Plans ___ Other _____

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

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 schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

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.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Informed Consent to Chiropractic Treatment from Kats Chiropractic

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____ _____ _____

Printed Name Signature Date

WITNESS:

_____ _____ _____

Printed Name Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with Kats Chiropractic's Notice of Privacy Practices.

- It tells me how Kats' Chiropractic will use my health information for the purposes of my treatment, and payment for my treatment
- The Notice of Privacy Practices explains in more detail how Kats Chiropractic may use and share my health information for purposes other than treatment, payment, and health care operations.
- Kats Chiropractic will also use and share my health information as required/permitted by law.

Patient's Complete Legal Name: _____
(Please print)

Patient's DOB _____ Date: _____

Signature: _____
(Patient or legal representative*)

☐ Patient declined the Notice of Privacy Practices.

Reasons: _____

Patient signature: _____

Employee Signature: _____ Date: _____

*May be requested to show proof of representative status

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AUTHORIZATION TO DISCUSS PATIENT MEDICAL INFORMATION

This form gives us permission to discuss your medical information with your loved ones.
Fill this section out ***ONLY*** if there is someone(family member, friend, etc.) you would like for us to share information with.
I, _____, give permission to Kats Chiropractic and its staff to discuss (check as applicable): ☐ my diagnosis, ☐ my treatment, ☐ my bill with _____

_____.

_____
Patient Signature

*This authorization may be changed or revoked at any time by submitting a written request to Kats Chiropractic 2016 W. Houston Broken Arrow, Ok 74012

06/2014

OFFICE FINANCIAL POLICY

*******Please read carefully*******

COPAYS

All patients with a co-pay are required to pay their co-pay at the time of service. This is a contractual agreement both you and our office have with your insurance company.

INSURANCE DEDUCTIBLES

All patients with a deductible plan are required to pay the allowed amount at the time of your visit until the deductible has been met.

INSURANCE CHARGES

Charges and allowables are decided by your insurance company, not our office. In the event we are not aware of a charge which is not covered by your plan, you may be billed after we receive a denial from your insurance company.

INSURANCE ELIGIBILITY AND BENEFITS

Our staff does their best to verify your insurance and obtain benefits at the time of your visit. Remember this is only a quote from your insurance and *not a guarantee of payment from them*. Ultimately you as the patient are responsible for understanding your contract with your insurance carrier.

SELF-PAY

All patients who are self-pay are required to pay the full amount at the time services are rendered unless payment arrangements have been made.

GROUPON

Our office offers Chiropractic and/or Massage Therapy packages on Groupon. You may purchase both Chiropractic and Massage if you wish. ***Groupons are for new patients only***.

MISSED MASSAGE APPOINTMENTS

Since we have limited openings for massage we request that 24hours notice be given to reschedule or cancel***. If you no-show more than 2 massage appointments you will no longer be able to schedule further massage therapy sessions.***
Any cancelled or no-showed appointments without 24hrs notice will be subject to a ***$25 missed massage fee***. We do understand that there are times when 24hrs notice is not possible so emergency cancellations will be evaluated on a case by case basis.

PERSONAL/AUTO ACCIDENT INJURY CLAIMS

In most cases the medical bills in a personal/auto accident case are paid by the 3rd party (person at fault). In the treatment of these cases a Physicians Lien may be filed. This is standard procedure in the State of Oklahoma. It allows us to treat our patients without demanding payment in full up front. A Physician's Lien is a guarantee that the bill will be paid when the case ultimately is settled or goes to judgement. In some cases, the settlement that is agreed to by the patient is less that the total amount of our bill. ***Please be aware of this!*** You are ultimately responsible for the payment of your bill in full.

I HAVE READ AND UNDERSTAND THE KATS CHIROPRACTIC OFFICE FINANCIAL POLICY.

_____ _____

Patient/Guardian Signature Date