New Patient Information

NAME:_____ **DATE OF BIRTH:**_____
First middle last

ADDRESS:_____
street city state zip code

HOME PHONE: (_____)_____ **SOCIAL SECURITY #** _____

CELL PHONE: (_____)_____ **EMAIL:** _____

WORK PHONE: (_____)_____ **OCCUPATION:** _____

EMPLOYED BY: _____

Primary Care Physician: _____

MARITAL STATUS: **single** **married** **divorced** **widowed**

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

Designation of Authorization and Payment Agreement:

I do hereby designate Mark L. Bawcom, D.C. and The Bawcom Chiropractic Clinic to the fullest extent possible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b) 4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or health care expense(s) incurred as a result of the services I receive from the above names doctor.

I hereby assign to the physician all payments for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance including co-pays and deductibles. In the event of non-payment, my account may be turned over to a collection agency or attorney, and I will also be responsible for the cost of collection, and/or 33.3% for legal fees, and does further agree to pay interest on the unpaid balance at the rate of 18% per annum from the date that said monies became due and payable. This notice is effective as of _____and will expire seven years after the date on which you last received services from us.
DATE

_____ _____
print name date

_____ _____
patient signature date

PLEASE DO NOT WRITE BELOW THIS LINE.

DEDUCTIBLE AMOUNT ? _____ YTD MET _____ PT/OT DEDUCTIBLE ? _____ YTD MET _____

MAX # VISITS PER YEAR _____ MAX # MODALITIES/THERAPIES PER VISIT? _____ MAX BENEFIT PAY-OUT_____

REQUIRED REFFERAL? Y N REQUIRED REPORTING? Y N REQUIRED PRE-AUTH? Y N

□ CO-PAY _____ □ COINS _____

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health 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 stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history 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.

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.

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

DATE PATIENT INITIAL

Consent for use or disclosure of health information

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

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 hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of 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 services. We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this form (§164.520). 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. Please feel free to call us at any time for a copy of our privacy notices.

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 or 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.

You may revoke your consent to us 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 to revoke your authorization. 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 decided 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 this notice. _____

PATIENT INITIAL

Appointment Reminders and Health Care Information Authorization

Your Chiropractor 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 at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke you 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 receive your request to revoke your 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 decided 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 an 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, or other health related information at any time (§164.24).

I authorize you 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 INITIAL

_____ _____

PRINT PATIENT NAME DATE

_____ _____

PATIENT SIGNATURE DATE

_____ _____

PARENT/GUARDIAN (IF PATIENT IS A MINOR CHILD) OR REPRESENTATIVE (IF PATIENT IS DISABLED) DATE

PLEASE DO NOT WRITE BELOW THIS LINE.

_____ _____

AUTHORIZED PROVIDER SIGNATURE DATE

Patient Condition/ Symptom History

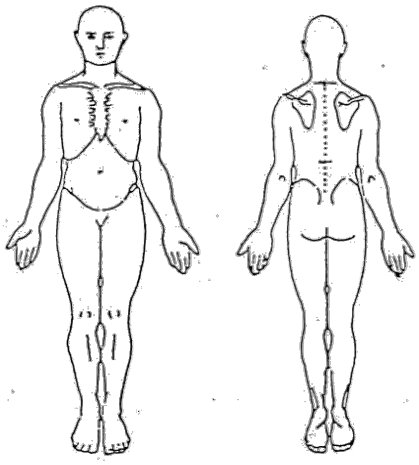
Briefly, what's the main reason for your visit today? _____

How long have you had these symptoms? _____

Is this condition due to an injury or accident? NO YES
(if yes, please explain)

_____

Where does it hurt?



(Mark the affected area(s) with an "X")

What kind of symptoms are you having? (please check all that apply)

□ sharp pain	□ dull ache, soreness	□ stiffness
□ sudden shooting pain	□ burning	□ cramping
□ tingling ("pins & needles")	□ swelling	□ headaches
□ numbness	□ muscle weakness	□ vertigo/dizziness

□other:_____

How often are you experiencing these symptoms?
□ occasionally (less than 25% of the time)
□ Intermittently (25% of the time or more)
□ Frequently (50% of the time or more)
□ Constantly (75% of the time or more)
□ Activity Specific (just while doing certain activities)

During which activities do you experience these symptoms?
(please check all that apply)

□ sitting □ bending □ standing □ lifting □ walking □ lying down □ other: _____

Does anything make it better? NO YES (if yes, please explain)

_____

Does anything make it worse? NO YES (if yes, please explain)

_____

Do these symptoms radiate to other parts of your body? NO YES (if yes, please explain)

_____

When do you experience the most discomfort?
□ morning □ afternoon □ evening □ during the night □ only during certain activities

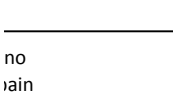
Have you received treatment for this condition before? NO YES
(if yes, briefly describe treatment/therapy you received)

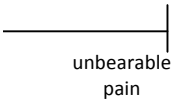
_____

Have previous treatments/therapies been helpful? NO YES SOMEWHAT

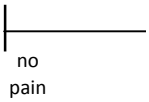
On the scales below, draw a vertical line representing your pain or discomfort:

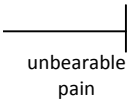
Rate the pain you have ***right now***:



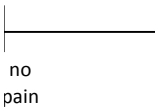


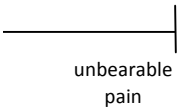
Rate your pain at its ***best*** this past week.



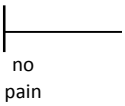


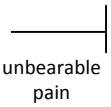
Rate your ***average*** pain this week.





Rate your pain at its ***worst*** in the past week.





Please list any conditions currently being treated by your primary care doctor with daily medication and/or supplements:

_____

Is there any other important information about your health you think the doctor should know? NO YES
(if yes, please explain)

_____

_____
print name

_____ _____
patient signature date