



Greene Chiropractic Clinic

1507-B Stillwater Ave, Cheyenne, WY 82009

Office: 307-637-7463 Fax: 307-778-9814

cheyennechiro@gmail.com

www.cheyennechiro.com

CONFIDENTIAL PATIENT INTRODUCTION

Date: _____

Patient's Full Name: _____ Nickname: _____
(Title) (First) (Middle Initial) (Last)

Primary Address: _____
(Street) (City) (State) (Zip Code)

Mailing Address (if different): _____

Date of Birth: _____ Age: _____ Sex: Male Female S.S.N. _____ - _____ - _____

Marital Status: S M W D Driver's License State and Number: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred method of contact for appointment reminders:

Home phone Work phone Cell phone Text message to cell (Wireless carrier: _____)

E-mail -- E-Mail Address: _____

Would you like to receive monthly newsletters and special announcements by e-mail? Yes No

Employer (or School): _____ Job Title: _____

Name of Spouse: _____ Is Spouse a Patient here? _____

Emergency Contact: _____ Relation to you: _____

Contact's Home Phone: _____ Cell Phone: _____ Work Phone: _____

Who (or what) referred you to our office? _____

INSURANCE INFORMATION: Health Savings or Flex Spending Account? Yes No

Primary Insurance Company: _____ Policy # _____

Insured's Name: _____ Employer: _____

Insured's Date of Birth: _____ Insured's S.S.N. _____ - _____ - _____

Secondary Insurance Company: _____ Policy # _____

Insured's Name: _____ Employer: _____

Insured's Date of Birth: _____ Insured's S.S.N. _____ - _____ - _____

(We will need a copy of your insurance cards and driver's license for our records)

AUTHORIZATION TO RELEASE INFORMATION:

Greene Chiropractic is authorized to release to any insurance companies having coverage on me (or to the employer if coverage is under a group insurance plan) any of my medical records pertaining to services rendered at this office. A copy of this authorization shall be considered as effective and valid as the original.

(Patient Signature)

(Date)

CONFIDENTIAL MEDICAL HISTORY FOR: (Please be complete)

Greene Chiropractic Clinic
1507 B Stillwater Ave.
Cheyenne, WY 82009

Name: _____ Height: _____ Weight: _____

List any allergies or health conditions you have: _____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.):

Have you been under a physician's care in the past year? no yes (reason) _____

When was your last physical examination? _____

Have you ever been under chiropractic care? no yes (describe) _____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.):

List all current over-the-counter and prescription medications used (include reason used):

List any surgeries (include dates & reason): _____

List any hospitalizations (include dates & reason): _____

List any auto accident injuries (include dates & reason): _____

List any on the job injuries (include dates): _____

If female, is there a possibility that you are pregnant? no yes

Do you smoke/use tobacco? no yes Exercise habits? never occasionally frequently

Check any of the following symptoms you have noticed: (= Previously, = Now)

- | | | |
|---|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> Leg/foot numbness/tingling | <input type="checkbox"/> <input type="checkbox"/> Irritability <u>or</u> depression |
| <input type="checkbox"/> <input type="checkbox"/> Dizziness <u>or</u> light-headed | <input type="checkbox"/> <input type="checkbox"/> Leg/foot fatigue/weakness | <input type="checkbox"/> <input type="checkbox"/> Fatigue <u>or</u> loss of energy |
| <input type="checkbox"/> <input type="checkbox"/> Muscles jerking/twitches | <input type="checkbox"/> <input type="checkbox"/> Leg pain with walking | <input type="checkbox"/> <input type="checkbox"/> Fainting <u>or</u> convulsions |
| <input type="checkbox"/> <input type="checkbox"/> Jaw pain, clicking, <u>or</u> locking | <input type="checkbox"/> <input type="checkbox"/> Radiating pain | <input type="checkbox"/> <input type="checkbox"/> Trouble w/ balance <u>or</u> coordination |
| <input type="checkbox"/> <input type="checkbox"/> Pain <u>or</u> difficulty swallowing | <input type="checkbox"/> <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> <input type="checkbox"/> Neck pain <u>or</u> stiffness | <input type="checkbox"/> <input type="checkbox"/> Nausea <u>or</u> vomiting | <input type="checkbox"/> <input type="checkbox"/> Sleep disturbances/problems |
| <input type="checkbox"/> <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> <input type="checkbox"/> Diarrhea <u>or</u> constipation | <input type="checkbox"/> <input type="checkbox"/> Rashes (face, body, limbs) |
| <input type="checkbox"/> <input type="checkbox"/> Mid back pain | <input type="checkbox"/> <input type="checkbox"/> Blood in urine <u>or</u> stool | <input type="checkbox"/> <input type="checkbox"/> Joint pain <u>or</u> swelling |
| <input type="checkbox"/> <input type="checkbox"/> Chest pain <u>or</u> cough | <input type="checkbox"/> <input type="checkbox"/> Difficulty <u>or</u> pain w/ urination | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis/loss of bone density |
| <input type="checkbox"/> <input type="checkbox"/> Pain/trouble breathing | <input type="checkbox"/> <input type="checkbox"/> Loss of bowel or bladder control | <input type="checkbox"/> <input type="checkbox"/> Pain w/ exertion (activity, stairs) |
| <input type="checkbox"/> <input type="checkbox"/> Blood pressure problems | <input type="checkbox"/> <input type="checkbox"/> Abnormal menstrual periods | <input type="checkbox"/> <input type="checkbox"/> A sore that won't heal |
| <input type="checkbox"/> <input type="checkbox"/> Arm/hand numbness/tingling | <input type="checkbox"/> <input type="checkbox"/> Sensitive to light <u>or</u> sound | <input type="checkbox"/> <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> <input type="checkbox"/> Arm/hand fatigue/weakness | <input type="checkbox"/> <input type="checkbox"/> Visual <u>or</u> hearing disturbances | <input type="checkbox"/> <input type="checkbox"/> Tumors |
| <input type="checkbox"/> <input type="checkbox"/> Low back pain | <input type="checkbox"/> <input type="checkbox"/> Memory loss/confusion | <input type="checkbox"/> <input type="checkbox"/> Bleeding disorders |

What is your primary complaint/problem? _____

List other symptoms: _____

When did your symptoms first begin (give date if possible)? _____

Any recent accidents or injuries (describe)? _____

How did your symptoms first begin? _____

Pain is: Constant Intermittent Getting worse About the same Somewhat less

What activities aggravate your condition? (list) _____

What activities lessen your symptoms? (list) _____

Is your condition worse at certain times of the day or night? _____

Have you had symptoms like this before? no yes (describe) _____

Does your condition interfere with: (yes/no) work _____ sleep _____ normal daily routine _____

List all Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

Who is your family medical doctor? _____



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FINANCIAL AGREEMENT,
ASSIGNMENT OF INSURANCE BENEFITS,
AND RIGHT OF RECOVERY

I, _____, do hereby agree to all of the following stipulations:
(Please print name)

- I understand and agree that all services rendered to me are charged directly to me, and that I am responsible for payment to Greene Chiropractic Clinic for all such services at the time that they are rendered. Payment is required at each visit.
- I fully understand and agree that my insurance policy(ies) are an arrangement between the insurance carrier(s) and myself. I will be responsible for expenses not paid by insurance, including insurance deductibles and co-payment amounts. I understand and agree that health or automobile insurance may not pay in full all of the charges incurred for my treatment. I understand and agree to pay the customary charges of Greene Chiropractic Clinic and agree that if my health or automobile insurance does not pay for my treatment in full, I will be responsible for the remaining balance. I understand and agree that I will be charged for missed appointments and it may be necessary for Greene Chiropractic Clinic to record a lien on my case to ensure payment, and I agree to pay the charges associated with filing of the lien.
- In consideration of services rendered at Greene Chiropractic, I hereby irrevocably assign and transfer all rights, title and interest in the benefits payable for services rendered by Greene Chiropractic Clinic provided by my insurance. Said irrevocable assignment and transfer shall be for the recovery on said policy(ies) of insurance, but shall not be construed to be an obligation of Greene Chiropractic to pursue any such right of recovery. I hereby authorize my insurance company(ies) to pay directly to Greene Chiropractic Clinic all benefits due under said policy(ies) by reason of services rendered therein. I will pay Greene Chiropractic Clinic for all charges incurred or alternatively, for all charges in excess of the sums actually paid pursuant to said policy(ies). A copy of this authorization shall be considered as effective and valid as the original.
- I further agree, that in the event I receive any checks, drafts or other payments subject to this agreement, I will endorse such payments directly to Greene Chiropractic Clinic, to be applied to my debt for services rendered.
- If insurance payment is not received within 60 days from the time insurance is filed, I understand that I will be billed for the remaining balance. I understand that interest in the amount of 1.5 % per month will accrue for any balance over 30 days and that any balance over 90 days will be turned over to collections and I will be responsible for any and all collection and attorney fees. These fees may be up to but not more than 50 % of my balance. I waive the Statute of Limitations regarding my doctor's right to recover.
- If I default in this agreement the entire balance becomes due, and I may be liable for court costs and attorney fees necessary to enforce collections of this debt. I understand that if I suspend or terminate my treatment, any fee for professional services rendered me will be immediately due and payable. An unpaid balance will be charged at the customary rate of one and a half percent (1.5 %) per month. I will be responsible for any legal expenses involved in the collection of such a past due account.

Signature of Patient (or Guardian for Minor)

(Date)



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Informed Consent for Chiropractic Care

- When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.
- Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.
- One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.
- Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.
- If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.
- All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name

Signature

Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Estimated date of last menstrual cycle: _____

Signature

Date

HIPAA Notice of Privacy Practices of GREENE CHIROPRACTIC CLINIC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care options, and for other purposes that are permitted and required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary treatment to diagnose or treat you. You may receive treatments and advice in an open room where others may see you, within reason and comfort level.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Options: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fund-raising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. It may be necessary for us to call your home, cell phone, or place of employment regarding appointment and/or insurance issues. We may need to leave messages on your answering machine or voice mail to provide information on treatments, insurance, and other health related information. We may also use your mailing address to send information about health insurance claims, billing statements, appointment reminders, special offers, birthday and holiday-related cards, and thank you cards or gifts.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues are required by law, Communicable Diseases: Health Oversight: Abuse of Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroner's, Funeral Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to Investigate or determine our compliance with the requirements of Section 164.500.

- **Other permitted and required uses and disclosures** will be made only with your consent, authorization, or opportunity to object unless required by law.
- **You may revoke or amend this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

- **You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative actions or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
- **You have the right to request a restriction of your protected health information.** This means as you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a Paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
- **You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy right has been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

_____ **Print Name**

_____ **Signature of Patient (or Guardian of Minor)**

_____ **Date**

Check here if you would like a copy of these practices to keep for your records.