Confidential Patient Information

(Please Print)
Name:____________________________________SS#__________________Date:____________

Birth Date: __/__/__Age:____Sex: M___F___Height:____Weight:_____Marital Status: S M W D

Home Address: ____________________City:_________________State:______Zip:__________

Home Phone#_____________ Cell Phone #________________ Work Phone #_______________

Email: _____________________Occupation:_________________Employer:_________________

Work Address: ____

Spouse Name:____________________________SS#__________________Birth Date:__________

Occupation:__________________Employer:________________Work Phone#_______________

# of Children______Who may we thank for referring you to our office?_____________________

Current Health Complaints: (in order of importance)

1. ____
2. ____
3. ____

Have you ever had same/similar problems before? Y/N If so, when and for how long?_________
List other Doctors you have consulted for these conditions:
Dr. Name:____________________________Address/ Phone:______________________________
Dr. Name:____________________________Address/ Phone:______________________________
List any medications you are currently taking:____
Are you currently being treated for any other health conditions that we should be aware of? If so
Please explain:____
____

Have you ever been to a Chiropractor before? Y/N When?________________________________

I am interested in a massage therapy evaluation and treatment if necessary. Y/N

If this is an injury sustained from an automobile accident or work related incident, please notify the front desk immediately. Additional forms may need to be completed.
Work related? Y/N Was your employer informed? Y/N
Auto accident? Y/N Date:_______Name and phone number of attorney:_____________________

Females: Pregnant? Y/N/Unsure Date of last cycle:_____________________________________

Initial consultation is complimentary. However, any additional first visit charges are due when services are rendered.
Method of payment for today's charges: Cash / Check / Charge

Insurance is not required to be a patient in our office. However, if you have insurance that may cover chiropractic care, we would be happy to verify that coverage for you. Please provide your insurance card(s) to the front desk and we will gladly research your insurance benefits.

Signature required on this form.

____
Signature **Date**

AUTHORIZATIONS AND RELEASES FOR OGDEN FAMILIY CHIROPRACTIC

Name ____ Date _________________

CONSENT FOR TREATMENT

I,___________________, the undersigned, a patient in this office, hereby authorize Ogden Family Chiropractic's physicians and staff to administer treatment as is necessary and certify no guarantees or assurances have been made to me as to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from any insurance company and that the amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my credit. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand and agree to pay interest on any unpaid balance that is due at the conclusion/termination of the treatment administered At a rate of 1.5 percent interest per month (18 percent APR) or as allowed by law, until the balance is paid in full.

Patient Signature:____Date:_________________________________

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I authorize and instruct________________________________ Insurance company / Insurance administrator to pay by check and for it to be made payable to and mailed directly to Ogden Family Chiropractic with the expense benefits allowable and otherwise payable to me under current policy as payment toward the total charges for professional health care services rendered. I have agreed to pay, in a current manner, any balance of said professional charges. I hereby agree that this office be given the power of attorney to endorse/ sign my name on any and all drafts for payment of my bills.

If my current policy prohibits direct payment to the doctor, I hereby authorize, instruct and direct you to make out the check to me and mail as follows:

Ogden Family Chiropractic, 106 Marshall Ct., Wilmington, NC 28411

I authorize Dr. Daniel Maggio, DC, or his staff to initiate complaint to the Insurance Commission for any reason on my behalf.

Patient Signature:____Date:__________________________________

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I authorize the release of any health care information necessary to process my insurance claim's and also certify that all insurance information given to Ogden Family Chiropractic is correct and complete.

X-RAY/ HEALTH CARE RECORD RELEASE

I hereby request the release of my x-rays, notes, charts, and all other health care records (my records) which are a part of the records at the offices of ______________________________ (clinic) and request that my records be sent to ____________________

Patient Signature:____Date:__________________________________

CONSENT FOR TREATMENT OF MINOR

I hereby authorize Ogden Family Chiropractic's physicians and staff to administer chiropractic care, attention, and treatment as deemed necessary to my son/daughter named ____

Patient Signature: ____ Date: _______________________

PATIENT HISTORY Name: Date: Pt. #:

HAVE YOU EVER SUFFERED FROM OR BEEN DIAGNOSED AS HAVING:
(CIRCLE YES OR NO FOR EACH)

Y N BROKEN OR FRACTURED BONES
Y N CIRCULATORY PROBLEMS
Y N RHEUMATOID ARTHRITIS
Y N SEIZURES/CONVULSIONS
Y N A CONGENITAL DISEASE
Y N EXCESSIVE BLEEDING
Y N HIGH/LOW BLOOD PRESSURE
Y N DIABETES
Y N OSTEOARTHRITIS
Y N EPILEPSY
Y N PACEMAKER
Y N STROKES
Y N CANCER
Y N ULCERS
Y N RUPTURES
Y N COUGHING BLOOD
Y N EATING DISORDER
Y N ALCOHOLISM
Y N DRUG ADDICTION
Y N HIV POSITIVE
Y N GALL BLADDER
Y N HEAD/SKULL TRAUMA
Y N DEPRESSION
Y N TUMORS

WHEN WAS YOUR LAST PHYSICAL EXAM?____

WHAT TYPE OF BODY POSTURES DO YOU REPETITIVELY USE OR SUSTAIN DURING YOUR AVERAGE DAY?

Y N SITTING
Y N STANDING
Y N INTRICATE WORK WITH HANDS
Y N BENDING
Y N CRADLING PHONE
Y N ARMS OVERHEAD
Y N LIFTING
Y N ARMS EXTENDED FORWARD
Y N LOOKING UP
Y N WALKING
Y N HEAD BENT FORWARD
Y N CLIMBING STAIRS

OTHER ____

____

HOW OFTEN DO YOU DRINK CAFFEINATED BEVERAGES? ______________________________
HOW OFTEN DO YOU DRINK ALCOHOLIC BEVERAGES?__________________________________
DO YOU SMOKE?_____YES_____NO HOW MUCH?_____________________________________
DO YOU EXERCISE?_____YES_____NO HOW OFTEN?___________WHAT TYPE?_____________
____
____

PLEASE LIST AND IDENTIFY WITH A CHECK MARK ALL VITAMINS (V), PRESCRIPTION (Rx), AND NON-PRESCRIPTION (NON-Rx) MEDICATIONS YOU HAVE TAKEN OVER THE PAST YEAR AND/OR ARE CURRENTLY TAKING: (CIRCLE WHO PRESCRIBED, D = DOCTOR , OR S = SELF)

MEDICATION LIST

NAMES OF MEDICATION OR VITAMINS	V	NON-Rx	Rx STRENGTH	DATE STARTED	DATE STOPPED	WHO? D/S
						D S
						D S
						D S
						D S
						D S

___NDRA DRUG ALLERGIES:

Ogden Family Chiropractic

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

To:

Ogden Family Chiropractic
106 Marshall Ct.
Wilmington, NC 28411

Patient Name: ____
Date of Birth: ____________ Social Security Number: _________________

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

☐ All physical, occupational and rehab requests, consultations and progress notes.

☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

☐ All employment, personnel or wage records.

☐ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period ____________ to ______________.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information. This protected health information is disclosed for the following purposes:

____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

____
Name of Representative

____
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

____
Street Address

____
City, State and Zip Code

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open-adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine detail of care is discussed

within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment, other arrangements will be made for you.

If for any reason you choose to have a private conversation with the doctor or staff, arrangements will be made at the time of the request to address questions or concerns in the privacy of a closed meeting room.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

____ ___________

Signature of Patient or Legally Authorized Representative Date

____

Name and Relationship of Legally Authorized Representative to Patient
(See 45CFR §164.508(c)(1)(iv)

____ __________________

Witness Signature Date