

INFORMATION/ APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **PLEASE PRINT**

Name: _____ Birthdate: ___/___/_____ Sex: M F

Address: _____ City: _____ Zipcode: _____

Soc. Sec. #: _____ - _____ - _____ Home Phone: _____ Work Phone: _____ Email: _____

Marital Status: M S D W Children, Ages: _____ Spouses Name: _____

Occupation: _____ Employer: _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major Complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____ Better? _____

Is this condition: Improved Unchanged Getting Worse

Is this condition interfering with your: Work Sleep Daily Routine Other: _____

Other Doctors or Therapist who have treated THIS condition? _____

What do you think caused this condition? _____

List surgical operations and years: _____

Do you have a family physician? _____

Medications and Dosage and Frequency: _____

Have you been an auto accident or had any other Personal injury? Y N Describe: _____

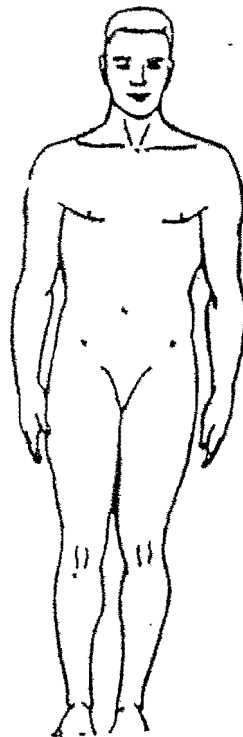
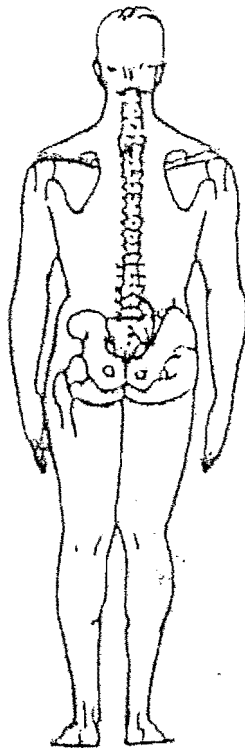
Patient Name _____ Acct.# _____ Date _____

COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of the pain, as well as any activity which brings on or aggravates the pain. For example.... Dull, Sharp, Consistent, constant, intermittent, while sitting or standing.

Front

Back



MARK AN "X" ON THE LINES:

How bad are your symptoms now?

0 _____ 10
None Severe

How bad have they been in the past?

0 _____ 10
None Severe

Notice to patients: Full payment for services rendered is due at the end of each visit. If for any reasons this request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance cases: All insurance deductible should be paid in the beginning of care unless prior arrangements have been made.

Patients Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

PLEASE PRINT

What's your major complaint? _____

List surgical operations and years: _____

Drugs you now take: Nerve pills Pain killers Muscle relaxers "Pep" pills Tranquilizers Birth control pills.

Others: _____

Age of mattress: _____ Comfortable Uncomfortable Do you use a bed board? _____

Describe: _____

Are you wearing: Heal lifts Sole lifts Inner soles Arch supports

Have you been in an auto accident: Past year past five years Over five years Never

Describe: _____

Have you ever had any mental or emotional disorders? Yes No When? _____

Have others in your family had such disorders? Yes No When? _____

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Used a cane, crutch, or other support?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had a fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized for anything other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

DO YOU:

Now take vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Think you may need vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have an allergy to any drug?	<input type="checkbox"/>	<input type="checkbox"/>	_____

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

NAME _____

ADDRESS: _____ PHONE: _____

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

- 1. If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed \$100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.
- 2. If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed \$100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered or by an authorized payment plan. We will continue to provide you with an insurance claim form.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: _____

Signature: _____ Date: _____

Finance Counselor: _____ Date: _____

Front Desk: _____ Date: _____

For your convenience you may retain your credit card number on file with us.

Card #: _____ Expiration Date: _____

Name as appears on card: _____

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

If you have any questions about this Notice, our Privacy contact Person is Teresa Sweatman.

1. Optimal Health Chiropractic may use and disclose your health information for treatment, payment and healthcare operations. An example of release of your information for treatment purposes, would include, but not be limited to, consultations or referrals to other healthcare providers. In the case of release of your information for the purposes of payment, examples would include, but not limited to, insurance companies for submitting claims; verifying insurance coverage; insurance authorization for service. For the case of healthcare operations, your information could be released for the purpose of internal quality control and assurance; chart audits, and other uses necessary, for the administration of our practice such as the use of a sign-in sheet or calling your name in our waiting room when the doctor is ready to see you.
2. Optimal Health Chiropractic is permitted or required to release your health information without your written consent or authorization in certain circumstances. Two examples of such circumstances would be for public health requirements or court orders.
3. Optimal Health Chiropractic may at times contact our patients to provide appointment reminders or information regarding treatment alternatives or other health related benefits and services that our staff feels might be of interest to our patients.
4. Optimal Health Chiropractic will honor your health information rights. Although your health record is the property of our practice, the information belongs to you. You have the right to:
 - a. Inspect and request a copy of your health record.
 - b. Request a restriction on certain uses and disclosures of your information.
 - c. Obtain an accounting of disclosures of your health record.
 - d. Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
 - e. Amend your health record.
 - f. Request communications of your health information by alternative means or at alternative locations.
 - g. Obtain a copy of our Notice Of Privacy Practices upon request.
5. Optimal Health Chiropractic will abide by the terms of this notice or the notice currently in effect at the time your information is released.
6. Optimal Health Chiropractic reserves the right to change the terms of this notice and to make the new notice effective for all patient information that it maintains.
7. Optimal Health Chiropractic will provide you a copy of any changes of this notice at the time of your next visit or at your last known address if there is a need to release your health information. Copies may be obtained at any time at our office.
8. Any person may file a complaint to our Practice if they believe their privacy rights have been violated. To file a complaint, please fill out a report form located with the receptionist. You may give the report to the receptionist during working hours or you may remain anonymous by mailing the report to our office at anytime. You may also report directly to the South Carolina Secretary of Health and Human Services in Columbia.
9. It is Optimal Health Chiropractic's policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.
10. The effective date of this Notice of Privacy Practices is April 14, 2003

SIGNED _____

DATE _____

(Print Name)