CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

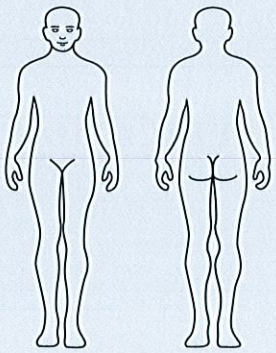
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

THE CHIROPRACTIC CARE CENTER
AUTHORIZATION FORM

www.docmasonwv.com

PATIENT NAME_____ PATIENT NO._____

PREGNANCY RELEASE FOR X-RAYS (FEMALES ONLY)

I hereby advise this office and doctor(s) that I am not pregnant as of this date. I release the doctors and staff from any liability for injury or complication to myself or my fetus should I be pregnant on this date. I further agree to notify this office in writing during the course of my care should I become pregnant.

Signature _____

RESPONSIBILITY OF BILL

The undersigned hereby accepts full financial responsibility for charges and services rendered to the patient. The undersigned understands that services are rendered and charged to the patient and not to the insurance company. The Chiropractic Care Center cannot accept total responsibility for collecting an insurance claim or negotiating a disputed settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges and services not covered by insurance for which payment is denied through may utilization review or precertification procedures. I understand that most insurance companies, including Medicare and Medicaid, will NOT pay for "Maintenance Care" or "Wellness Care". Therefore, our office does not bill 3rd Party Payers for "Maintenance" or "Wellness" Care. If you are seeking Maintenance or Wellness Care, please advise our doctors and staff so that alternative payment arrangements can be made. Additionally, if the third party payor denies payment due to considering your treatment to be "Wellness" or "Maintenance" care, I understand that I am still personally responsible for paying any fees associated with treatment at this Chiropractic facility.

Signature _____

CONSENT FOR TREATMENT OF MINOR CHILD

Consent is hereby given by the undersigned for chiropractic treatment and diagnostic studies as ordered by the doctors and performed by the technical staff of Mike Mason Chiropractic. The undersigned states that he/she is the patient's legal guardian. I/We hereby authorize The Chiropractic Care Center to display my/my child's photo in the office on our "Wall of Fame". No patient information will be disclosed other than this photo. I may revoke this privilege at any time with a written request to the office.

Signature _____

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby irrevocably authorize payment of the medical benefits otherwise payable to me to be made payable and mailed directly to The Chiropractic Care Center for professional services rendered. NO OTHER THIRD PARTY, including my attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges medical coverage and will send payments directly to this office. This payment will not exceed my indebtedness to the doctor/ clinic. I agree that a photostatic copy of this agreement shall serve as the original.

Signature _____

AUTHORIZATION TO BILL FOR SERVICES:

I hereby understand that The Chiropractic Care Center offers a complimentary consultation and preliminary spinal screening/postural analysis for which there is no charge. I understand that any services beyond these complimentary services shall be billed at the usual and customary fees. Such services include, but are not limited to, examinations, x-rays, adjustments, and any therapeutic modalities.

Signature _____

AUTHORIZATION TO COORDINATE MEDICAL RECORDS WITH OTHER PROVIDERS:

I hereby understand that The Chiropractic Care Center will attempt to coordinate care with all other healthcare providers that a patient may have. This is done by sharing your Chiropractic records with the other providers in order to coordinate your care. I hereby give my consent to have my Chiropractic records, including but not limited to, evaluations, daily treatment notes, any and all testing results, and any other medical information the Doctors deem necessary, sent to any other healthcare providers that I currently have, as well as to any other providers to which I am referred by the Doctors of the Chiropractic Care Center.

Signature _____

_____	_____	_____
PATIENT, AGENT, OR REPRESENTATIVE	WITNESS	DATE

The Chiropractic Care Center, PLLC

Michael W. Mason, D.C. * Susan Beall, D.C. * Craig Kelley, D.C. * Kyle Hart, D.C. * Chad Porter, D.C.

529 East Main St., Bridgeport, WV 26330 * 200 Route 98 West Suite 105, Nutter Fort 26301

Bridgeport Phone: (304)842-4202 * Nutter Fort Phone: (304)969-9508

Please remember that your insurance coverage/plan is an agreement between you and your insurance company, not between your insurance company and this office. We CANNOT be certain if your insurance covers Chiropractic, although most insurance companies do. The amount that they will pay varies from one policy to another and from one insurance company to another. Verification of your insurance coverage is YOUR responsibility. Please make sure to call the 800 number on the back of your insurance card to obtain the specifics about your particular coverage. It is understood and agreed that any services rendered may be charged to you directly and that you are personally responsible for payments of any non-covered services, deductibles, co-insurance and/or copays.

I have read and fully understand the above information:

_____ _____

Signature Date

_____ _____

Witness Date

The CHIROPRACTIC CARE CENTER

529 East Main St. Bridgeport, WV 26330 *304.842.4202*
200 Rt. 98 West Ste. 105 Nutter Fort, WV 26301 *304.969.9508*

PREGNANCY WARNING AND CONSENT TO X-RAY

Patient Name_____ Date_____

☐ I am a male patient. This does not apply to me, but I DO consent to take x-rays.

I understand that if I am pregnant and have x-rays, which expose my lower torso to radiation, taken it is possible to injure the fetus.

I have been advised that the 10 days following onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

	YES	NO	DON'T KNOW
I am pregnant	_____	_____	_____
I could be pregnant	_____	_____	_____
I am late with my menstrual period	_____	_____	_____
I am taking oral contraceptives	_____	_____	_____
I have an IUD	_____	_____	_____
I have had a tubal litigation	_____	_____	_____
I have had a hysterectomy	_____	_____	_____
I have irregular menstrual periods	_____	_____	_____

My last menstrual periods began on _____

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed.

Patient Signature_____

Witness_____

The Chiropractic Care Center, Bridgeport, WV 26330 & Nutter Fort, WV 26301

Patient's Name:_____ **Insurance ID#:**_____

ADVANCE BENEFICIARY NOTICE of NONCOVERAGE (ABN)

NOTE: If your health insurance plan doesn't pay for adjustments and/or modalities below, you may have to pay.

Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect that **your insurance may not pay for the services below:**

Service:	Reason Your Insurance Plan May Not Pay:	Estimated Cost:
EVALUATIONS	**BENEFITS EXHAUSTED/ NON-COVERED SERVICES**	$50-$240
RE-EVALUATIONS		$25-$125
ADJUSTMENTS (CMT)		$41-$65
E-STIM (EMS)		$25
MECHANICAL TRACTION		$30
X-RAYS		$75-$350

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services listed above. **NOTE: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your insurance cannot require us to do this.**

OPTIONS: Check only ONE box. We cannot chose a box for you
☐ Option 1. I want the Service(s) listed above. You may ask to be paid now, but I also want my health insurance plan billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if my health insurance plan doesn't pay, I am responsible for payment but I can appeal to my health insurance plan by following the directions on the EOB. If my insurance plan does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ Option 2. I want the Service(s) listed above, but do not bill my health insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my health insurance plan is not billed.**
☐ Option 3. I don't want the Service(s) listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my health insurance plan would pay.**

Additional Information:

This notice gives our opinion, not an official decision of your health insurance plan. If you have other questions on this notice or your particular insurance plan coverage, please call the toll-free number on the back of your insurance card. Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

The Chiropractic Care Center of NUTTER FORT
200 Route 98 W. Suite 105
Nutter Fort, WV 26301
Phone: 304.969.9508
Fax: 304.918.9397

Patient's Authorization to Release Information

DATE: _____

TO: _____
_____
_____

"I HEREBY AUTHORIZE THE ABOVE NAMED FACILITY TO FURNISH THE OFFICE OF *THE CHIROPRACTIC CARE CENTER* WITH THE INFORMATION REQUESTED BELOW."

PLEASE SEND:

- ( ) COMPLETE RECORDS
- ( ) RADIOLOGY REPORTS
- ( ) MRI REPORTS
- ( ) CT REPORTS
- ( ) OTHER: _____

PATIENT'S NAME: _____
DATE OF BIRTH: _____

PATIENT'S SIGNATURE: _____

THANK YOU!

******CONFIDENTIALITY NOTICE******
The documents accompanying this telecopy transmission contain confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled, unless otherwise required by state law.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for return of these documents.

I hereby release The Chiropractic Care Center from all legal liability that may arise from this and any further disclosure of said records. I understand that this authorization is valid for six (6) months from the date of signature. I may revoke this authorization, in writing, at any time prior to the actual release of said records.

INFORMED CONSENT FOR TREATMENT

PATIENT NAME: **PATIENT FILE #:**

Physicians and other health care providers are required to obtain your informed consent before starting treatment.

I _____ do hereby give my consent to the performance of chiropractic treatment that may consist of manipulations/adjustments, physical medicine and exercises. I understand that the manipulations/adjustments will involve movement of the joints and soft tissues that is considered to be one of the safest and most effective form of therapy for musculoskeletal problems.

I am aware that there are possible risks/complications associated with my treatment. Tests have been performed to minimize these risks. I freely assume the risks of treatment after having been informed of the possible risks/complications associated with my treatment as follows:

Soreness: *It is common to experience muscle soreness during treatment.*
Uncomfortableness: *Temporary symptoms (dizziness, nausea) can occur, but are rare .*
Fractures/Joint Injury: *Underlying physical defects, deformities or pathologies (osteoporosis) may cause susceptibility to injury.*
Stroke: *Strokes from chiropractic adjustments are rare.*
Burns: *Some therapies used generate heat and may, in rare cases, cause burns.*

Treatment results: I understand there are benefits associated w/treatment including decreased pain, improved mobility and function, and reduced muscle spasms. However, I also understand there is no guarantee that I will achieve these benefits during my care, as the practice of medicine, including chiropractic, is not an exact science.

Alternative Treatments Available: Reasonable alternatives to treatment have been explained to me including rest, home therapy, exercises, medication and possible surgery.

I agree to treatment by my doctor and such persons of the doctor's choosing and provide my informed consent for treatment.

I HAVE READ OR HAVE HAD READ TO ME THE ABOVE EXPLANATION OF CHIROPRACTIC TREATMENT. ANY QUESTIONS REGARDING TREATMENT HAVE BEEN ANSWERED TO MY SATISFACTION.

_____
Patient's Signature

_____
Witness Signature

_____
Date

PATIENT STATUS AT TIME OF CONSENT:

( ) OF LEGAL AGE
( ) ORIENTED x3
( ) COHERENT/LUCID
( ) PROFICIENT ENGLISH
( ) ASSISTED BY INTERPRETER

_____

( ) MEDICATED, BUT UNIMPAIRED
( ) DENIES USE OFALCOHOL OR RECREATIONAL DRUGS PRIOR TO CONSENT
( ) UNABLE TO GIVE LEGAL CONSENT
( ) CONSENT VIA LEGAL GUARDIAN

_____

Patient's questions (if any) and responses are as follows:

Comments:

I certify that this form accurately reflects the patient's status during the informed consent process.

_____
Doctor Signature

_____
Date