PATIENT DATA SHEET

General Information

First Name ______
Middle Initial ______
Last Name ______
Called Name ______
Address ______
City ______
State ______
Zip Code ______
Home Phone ______
Work Phone ______
Cell Phone ______
Pager No. ______
Email Address ______
Sex Male Female
Race American Indian, Alaska Native, Asian, Black or African America, Native Hawaiian, Other Pacific Islander, White, Declined to State
Ethnicity Declined to State, Hispanic or Latino, Not Hispanic or Latino
Language ______
Marital Status Single Married Other ______
Birthdate ______
Social Security ______
Referred By ______
Work Status Employed Full-time student Part-time student
Appt Reminder ______

Insured's Information

Patient is the Same/Self Husband Wife Child Other of Insured
First Name ______
Middle Initial ______
Last Name ______
Address ______
City, State, Zip ______
Phone Number ______
Social Security ______
Date of Birth ______
Sex Male Female Unknown

Carrier Information

Name/Code ______
Attn ______
Address ______
City, State, Zip ______
Contact ______
Phone ______
Fax ______
Email Address ______
Web Site ______

For Office Use Only

Account Number ______
Account Category ______
Type of Account 1 2 3 4 5 6 7 8 9 Z
Code Set ______
Yearly Deductible ______
Deductible Rest Date ______
Unused Deductible ______
Copay ______
Patient Percentage ______
Household Mailing Yes No
Doctor Number ______
Maximum Charges ______
Max Charge per Day ______
Maximum Visits ______
Max Visits Since Diag ______
Max Treatment Date ______
Full Balance ______
Patient Balance ______
Diagnosis Codes ______

Coverage Information

Coverage Effective Date ______
Coverage Notes ______
Limitations Notes ______

Plan Information

Plan Name ______
Insurance ID ______
Group No ______
Benefits Primary Secondary Other
Coordination ______
Send Form To ______
Claim Type ______

Employer Information

Employer/Code ______
Attn: ______
Address ______
City, State, Zip ______
Contact ______
Phone ______

Condition Information

Related to Employment Yes No
Related to Auto Accident Yes No
Related to Other Accident Yes No
Similar Symptoms ______
Consultation Date ______
Condition Date ______

PATIENT DATA SHEET

General Information

First Name ______________________
Middle Initial ______________________
Last Name ______________________
Race (circle only 1) American Indian Alaska Native
Asian White
Black or African American
Native Hawaiian Other Pacific Islander
Declined to State

Ethnicity (circle only 1) Declined to State Hispanic or Latino
Not Hispanic or Latino

Preferred Language ______________________
Email Address ______________________

Smoking Status (circle only 1) Current Every Day Smoker
Current Some Day Smoker
Former Smoker
Never Smoker

Smoking Start Date: __________ End Date: __________

In an effort to quit smoking, I am currently taking: ______________________

For Office Use Only

Account Number ______________
Patient Height ______________
Patient Weight ______________
Patient BMI ______________
Patient Blood Pressure ______________

Do you have any allergies to medication? Yes No
If Yes, please indicate the following:

Allergy: ______________
Reaction: ______________
Start Date: ______________
End Date: ______________

Allergy: ______________
Reaction: ______________
Start Date: ______________
End Date: ______________

Allergy: ______________
Reaction: ______________
Start Date: ______________
End Date: ______________

Allergy: ______________
Reaction: ______________
Start Date: ______________
End Date: ______________

Are you currently taking any new medication since your last visit? Yes No
If Yes, please indicate the following:

Medication: ______________
Route: Oral
Intravenous
Other: ______________
Frequency: ______________
Began Use: ______________
Discontinued Use: ______________

Medication: ______________
Route: Oral
Intravenous
Other: ______________
Frequency: ______________
Began Use: ______________
Discontinued Use: ______________

Medication: ______________
Route: Oral
Intravenous
Other: ______________
Frequency: ______________
Began Use: ______________
Discontinued Use: ______________

Medication: ______________
Route: Oral
Intravenous
Other: ______________
Frequency: ______________
Began Use: ______________
Discontinued Use: ______________

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name ______________________ *Date* ______________________

1. Describe your symptoms ______________________

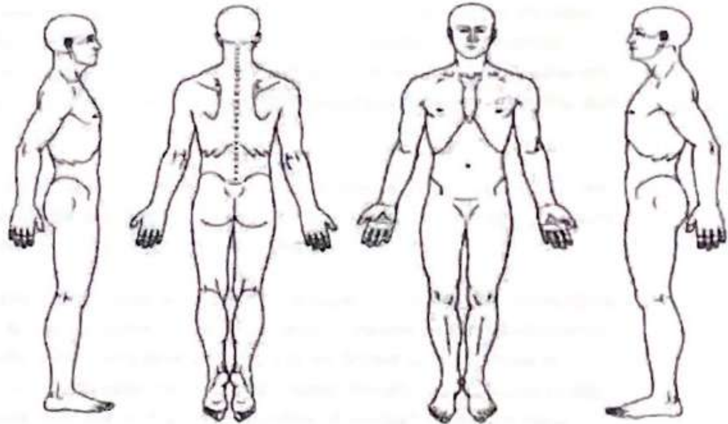
a. When did your symptoms start? ______________________

b. How did your symptoms begin? ______________________

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms — None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. What treatment did you receive and when? ______________________

b. What tests have you had for your symptoms and when were they performed?

① Xrays date: ________ ② MRI date: ________ ③ CT Scan date: ________ ④ Other date: ________

9. Have you had similar symptoms in the past?

① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

10. What is your occupation?

____

① Professional/Executive ② White Collar/Secretarial ③ Tradesperson ④ Laborer ⑤ Homemaker ⑥ FT Student ⑦ Retired ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

Patient Signature ______________________ *Date* ______________________

Authorization of Assignment

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities, which may elect or be obligated to pay, provide, or distribute pay directly and exclusively in the of Smith Chiropractic Group. Such sums as may be owing to Dr. Chris Smith for charges incurred by me at the office relating to my condition, which such payments to be made exclusively in the name of Smith Chiropractic Group. I further grant lien to Smith Chiropractic Group with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein, "Assignment of Lien"), benefits shall include, but not be limited to, proceeds from any settlement, judgement, or verdict, as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

In the event that I retain one or more attorneys to represent me in this matter who are not located in NORTH CAROLINA, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letters of protection cannot be revoked or modified without expressed written consent of this office.

I authorize this office to release any information regarding my treatment or pertinent to my case to all payers as defined above to facilitate collection under this assignment and lien. I further authorize and direct all payers to release to Smith Chiropractic Group any information regarding any coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this office to file a copy of this assignment and lien, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Smith Chiropractic Group to endorse/sign my name on any and all checks listing me as a payee which are presented to this office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize Smith Chiropractic Group to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due to Smith Chiropractic Group for their services. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Smith Chiropractic Group for all costs of such collection efforts, including but not limited to all court cost and all attorney fees.

This assignment and lien shall not be modified or revoked without the mutual written consent of Smith Chiropractic Group and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

Patient Name (Please Print):______________________________

Patient Signature:______________________________ Date:___/___/____

Name of Custodial Parent or Legal Guardian (please print):______________________________

Parent/Guardian Signature:______________________________ Date:___/___/____

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

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 a 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 your 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 your sign this consent 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.

Your right to limit uses or disclosures

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.

Your right to revoke your authorization

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 receive 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 decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

______________________ Printed Name	______________________ Authorized Provider Representative
______________________ Signature	______________________ Date
______________________ Date	

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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 your 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 decide 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 and 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 (§164.524).

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

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 name printed   Date

____________________________ ____________________________

Patient Signature   Authorized Provider Representative

____________________________ ____________________________

Personal Representative Printed   Personal Representative Signature

____

Description of personal representative's authority to act for the patient.

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PLYMOUTH CHIROPRACTIC CENTER

INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible__________________) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the physician of Chiropractic named here ________________________________ and/or other licensed physicians of Chiropractic who may treat me now or in the near future at this office. I have had an opportunity to discuss with Dr.__________________ and/or with office clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment: including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations and sprains. I do not expect the physician to be able to anticipate and explain all risks and complication. Further, I wish to rely on the physician to exercise judgement during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition (s) for which I seek treatment at this facility.

____
Print Patient's Name

____
Signature of Patient

____
Print Name of Representative

____
Signature of Representative

This form should be maintained in the patient's health record.