FOOTHILLS CHIROPRACTIC
MOVE BETTER, FEEL BETTER
7208 E Cave Creek Rd - Carefree, AZ 85377
Dr. Jeffery Ring ● Dr. Gail Shriner

Confidential Health Information

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards

Name: _____ Nick Name: _____ DOB: _____ Age: _____

Mailing Addr: _____ Physical Addr (if different: _____

City: _____ State: _____ Zip: _____ SSN: _____

Marital Status: [ ] Married (Spouses Name:_____) [ ] Single [ ] Divorced [ ] Widowed [ ] Separated

Cell Phone: _____ May we text you? _____ Cell Provider: _____
(For text reminders)

Home Phone: _____ Emergency Contact & Phone: _____

Email Address: _____

How did you hear about us? _____

Financial Information

[ ] Self Pay [ ] Insurance [ ] Medicare [ ] Worker's Compensation [ ] Lien

Primary Ins. Carrier: _____

Secondary Ins. Carrier: _____

Authorization for Release of Medical Information:

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. **(We will call to verify benefits on your insurance, however, benefits quoted are not a guarantee of payment.)** I also understand that if I suspend or terminate by schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charge on overdue accounts at the annual rate of 16%.

_____ _____

Signature of patient or patient's parent/legal guardian **Date:**

Patient Reported Symptoms

Please describe your Primary Complaint in the space below. Use Secondary complaint boxes if they apply.

Primary Complaint:

How did it happen: _____ **When did it happen:** _____

Related to:

[ ] Worsening long-term problem [ ] An accident or injury due to:
[ ] Work [ ] Auto [ ] Other: _____

How did the problem start originally? _____

Has it become worse? [ ]Yes [ ] No [ ] Same [ ] Better

If yes, when and how? _____

How frequent is the condition? **How long does it last?**

[ ] Constant [ ] Daily [ ] Intermittent [ ] Night only [ ] All Day [ ] Few Hours [ ] Minutes

Have you lost days from work? [ ] Yes [ ] No

Any other conditions or symptoms that may be related?
[ ] Yes [ ] No If yes, describe: _____

Any unrelated health problems? [ ] Yes [ ] No
If yes, describe: _____

Describe the pain: [ ] Sharp [ ] Dull [ ] Numbness [ ] Tingling [ ] Aching [ ] Burning [ ] Stabbing
[ ] Other: _____

Is there anything you can do to relieve the problem?
[ ] Yes [ ] No If yes, describe: _____
If no, what have you tried? _____

What makes the problem worse? [ ] Standing [ ] Sitting [ ] Lying [ ] Bending [ ] Lifting [ ] Twisting
Other: _____

Have you broken any bones? [ ] Yes [ ] No If yes, please list and give dates: _____

List an major accidents you have had other than those mentioned above: _____

To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either past or present?
[ ] Yes [ ] No If yes, please explain: _____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? [ ] Yes [ ] No [ ] Uncertain

Have you been treated for any health condition by a physician in the last year? [ ] Yes [ ] No

If yes, describe: _____

No Symptoms _____ Extreme Symptoms

Please place an "X" on the line above to indicate your level of problem

Doctor's Signature: _____ Date: _____

EHR Questions

Name: _____ **DOB:** _____

VITALS:

BP: _____ Height:_____ Weight:_____ Pulse:_____ Temp:_____

Prescription Medications:

Name:	Treated for:	Dose:	Frequency:

Do you have any know DRUG allergies? [ ] Yes [ ] No If yes, please list them and allergic reactions:

_____

Surgical History:

Date:	Surgery:	Results:

Hospitalizations: [ ] Yes [ ] No If yes, list reason and date: _____

Please list any illnesses or conditions you have had or been diagnosed with (Date & Describe):

_____

_____

Immunizations:

Pneumonia [ ] No [ ] Yes, Date: _____ Tetanus [ ] No [ ] Yes, Date: _____

Shingles [ ] No [ ] Yes, Date: _____ Flu [ ] No [ ] Yes, Date: _____

Bloodwork Taken: [ ] No [ ] Yes, Date: _____ Results: [ ] Normal [ ] Abnormal

Family History: Cancer, Heart Disease, Blood Pressure, Arthritis, Diabetes, Stroke

Relationship:	History	Birth Year	Deceased	Year of Death	Cause

Social History:

Married: [ ] Yes [ ] No **Caffeine Use:** [ ] Yes [ ] No How Much: _____

Tobacco Use: [ ] Yes [ ] No How much: _____ **Drug Use:** [ ] Yes [ ] No How much: _____

Alcohol Use: [ ] Yes [ ] No How much: _____ **Exercise:** [ ] Yes [ ] No How much: _____

Occupation: _____ **Status:** Employed Retired Student

(Circle one)

Patient Health Information Consent Form

The Department of Health and Human services has established a PRIVACY RULE as part of THE HIPAA ACT OF 1996. HIPPA was also created in order to provide a standard for providers to obtain patients' consent for uses and disclosures of health information about the patient in order to carry out treatment, payment or health care operations. We require your consent below before we treat you.

1 We respect the privacy of your personal medical records. When appropriate or necessary, we will provide the minimum information to only those who are in need of your health, treatment or payment information. (i.e. Insurance providers)
2 The patient has the right to examine and obtain a copy of their own health records at any time and request corrections. The patient may request to know what disclosure have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3 A patient's written consent need only be obtained one time for all subsequent care given by this office.
4 The patient may provide a written request to revoke consent at any time during care. This would not effect use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5 Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
6 We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA Notice and office policies contain information regarding payment, health insurance, collections and other important information.
7 If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtains a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

Print Name: _____

Signature: _____ Date: _____

FOR OFFICE USE ONLY:

We have made every effort to obtain written acknowledgement of receipt of our HIPAA Notice from this Patient but it could not be obtained because:

[ ] Patient refused to sign
[ ] We were not able to communicate with the patient
[ ] Due to an emergency situation is was not possible to obtain a signature
[ ] Other, (provide details)

_____

Patient Name: _____
Staff Member Name: _____
Staff Member Signature: _____ Date: _____

Billing and Collection Policies

With the continued changes of insurance policies and procedures, we've found it necessary to outline some of our billing and collection policies. Please remember that each patient has an individual insurance policy and coverage may vary from plan to plan. Therefore, we may direct you to your insurance company to answer further questions.

1 **It is patient responsibility to know whether we are a preferred provider or contracted on your insurance Plan.**

_____ INITIALS

2 **Massage Cancellation/No Show Policy: All cancellations must be 24 hours prior to the scheduled appointment. <u>Those cancelled inside the 24 hour period or no shows will be charged $35</u>.**

_____ INITIALS

3 **It is patient responsibility to:**
***Provide us with accurate insurance information**
***Assist in contacting your insurance on any claims past due after 45 days**
***Pay all deductible, copays and coinsurance due at the time of service**
***Agree that all charges not directly paid by insurance company will be patients responsibility**

_____ INITIALS

4 **For self pay (no insurance) Payment is due at time of service**

_____INITIALS

5 **Co-payments: by law we must collect your insurance carrier designated co-pay.**

_____INITIALS

I have read and understand the above policies.

Print Name:_____

Signature: _____ Date: _____