

Victory Chiropractic & Spinal Decompression

PATIENT INFORMATION

Name:

(LAST)

(MI)

(FIRST)

Address:

(STREET)

(CITY)

(STATE)

(ZIP)

Home Phone:

Work Phone:

Cell Phone:

Email Address:

DOB: / /

Soc. Sec # : - -

Marital Status: S M W

Spouse's Name:

Employer:

Occupation:

Referred By:

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name:

Member #:

Group #:

Insurer's Name (If Different From Patient):

Insurer's DOB: / /

Insurer's Soc. Sec #: - -

Insurer's Employer:

Person responsible for account:

I 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 that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient/Guardian Signature

Date:

Victory Chiropractic & Spinal Decompression

IMPORTANT: Please place an X next to all present symptoms.

HEAD

- Headache
 - Sinus (Allergy)
 - Entire Head
 - Back Of Head
 - Forehead
 - Temples
 - Migraine
- Head Feels Heavy
- Loss Of Memory
- Light Headedness
- Fainting
- Light Bothers Eyes
- Blurred Vision
- Double Vision
- Loss of Vision
- Loss of Taste
- Loss of Balance
- Dizziness
- Loss of Hearing
- Pain in Ears
- Ringing In Ears
- Buzzing in Ears

NECK

- Pain In Neck
- Neck Pain w/Movement
 - Forward
 - Backward
 - Turn to Left
 - Turn to Right
 - Bend to Left
 - Bend to Right
- Pinched Nerve In Neck
- Neck Feels Out of Place
- Muscle Spasms in Neck
- Grinding Sounds in Neck
- Popping Sounds in Neck
- Arthritis in Neck

SHOULDERS

- Pain In Shoulder Joint (R-L)
- Pain Across Shoulders
- Bursitis (R-L)
- Arthritis (R-L)
- Can't Raise Arm (R-L)
 - Above Shoulder
 - Over Head
- Tension in Shoulders
- Muscle Spasms (R-L)

ARMS & HANDS

- Pain in Upper Arm (R-L)
- Pain in Elbow (R-L)
- Movement Aggravated
- Tennis Elbow (R-L)
- Pain in Forearm (R-L)
- Pain In Hands (R-L)
- Pain In Fingers (R-L)
- Pins & Needles Sensation - Arms (R-L)
- Pins & Needles Sensation - Fingers (R-L)
- Numbness in Arm (R-L)
- Numbness in Fingers (R-L)
- Fingers "Fall Asleep" (R-L)
- Hands Cold (R-L)
- Swollen Joints In Fingers (R-L)
- Sore Joints in Fingers (R-L)

ARMS & HANDS (continued)

- Arthritis In Fingers (R-L)
- Loss of Grip Strength (R-L)

MID-BACK

- Mid-Back Pain
- Location _____
- Pain Between Shoulder Blades
- Sharp Stabbing
- Dull Ache
- Pain From Front to Back
- Muscle Spasms
- Pain in Kidney Area

CHEST

- Chest Pain
- Shortness of Breath
- Pain Around Ribs
- Breast Pain
- Dimpled or Orange Peel Breast
- Irregular Heartbeat

ABDOMEN

- Nervous Stomach
- Food Unable to Eat _____
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW-BACK

- Low Back Pain
 - Upper Lumbar
 - Lower Lumbar
 - Sacroiliac
- Low Back Pain Is Worse When:
 - Working
 - Lifting
 - Stooping
 - Standing
 - Sitting
 - Bending
 - Coughing
 - Lying Down (Sleeping)
 - Walking
- Pain Relieves When: _____
- Slipped Disk
- Low Back Feels Out of Place
- Muscle Spasms
- Arthritis

HIPS, LEGS & FEET

- Pain in Buttocks (R-L)
- Pain in Hip Joint (R-L)
- Pain Down Leg (R-L)
- Pain Down Both Legs
- Knee Pain
 - Inside
 - Outside
- Leg Cramps (R-L)
- Cramps in Feet (R-L)
- Pins & Needles Sensation in Legs (R-L)
- Numbness of Leg (R-L)
- Numbness of Feet (R-L)
- Numbness of Toes (R-L)
- Feet Feel Cold (R-L)
- Swollen Ankles (R-L)
- Swollen Feet (R-L)

WOMEN ONLY

- Menstrual Pain _____ (Location)
- Cramping
- Irregularity
- Cycle _____ Days
- Birth Control _____ (Type)
- Hysterectomy
- Genital Cancer
- Discharge
- Color _____
- Tumors
- Abortions
- Menopause

MEN ONLY

- Urinary Frequency
- Difficulty In Starting
- Night Urination
- Prostate Pain/Swelling

GENERAL

- Nervousness
- Irritable
- Depressed
- Fatigue
- Feel Run-Down
- Normal Sleep _____ Hours per Night
- Loss of Sleep _____ Hours per Night
- Loss of Weight _____ lbs.
- Weight Gain _____ lbs.
- Coffee _____ Cups per Day
- Tea _____ Cups per Day
- Cigarettes _____ Packs per Day
- Exercise _____ Times per Week
- Alcohol _____ Drinks per Week
- Diabetes
- Hypoglycemia
- Other _____

Remarks

As a courtesy, Victory Chiropractic & Spinal Decompression will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

Patient Name (Printed)

Patient Signature

Date

Office Manager

Date

Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

In this office, we use trained assistants who may assist the physician with portions of your consultation, examination, and rehabilitative therapies.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

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

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always provide you with the best care and if results are not acceptable, we will refer you to another health care provider who we feel may assist your condition.

If you have any questions on the above information, please ask your physician. Once you have a full understanding, please sign and date below.

Patient's Name (Printed) _____

Date _____

Patients Signature _____

Guardian's Signature (if patient is a minor) _____

Witnessed By _____

Date _____

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of you Protected Health Information

Your protected health information will be used by Victory Chiropractic and Physical Therapy or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. This office may or may not agree to your request to restrict the use or disclosure of your protected health information. If we agree to your request, the restriction will be binding with this office.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health received will not be affected

Reservation of Right to Change Privacy Practice

This office reserves the right to modify the privacy practices outlined in the Notice.

I have reviewed the above information and give my permission to Victory Chiropractic to use and disclose my health information I accordance with it.

I have received a copy of Victory Chiropractic and Physical Therapy's Notice of Privacy Practices.

Name of Patient (Print)

Signature of Patient

Date

Signature of Patient Representative

Date

Relationship of Patient Representative to Patient

Office Representative

Date

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

All Patient Medical Records

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Name of person/organization
Victory Chiropractic & Spinal Decompression
Name of person/organization

Expiration Date of Authorization

This authorization is effective through 12/2013 unless revoked or terminated by the patient or patient’s personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

The use or disclosure requested under this authorization **will will not** result in direct or indirect remuneration to this office.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize Victory Office Manager to use my protected information for the listed reasons.

Signature

Name of Patient (Print)

Signature of Patient **Date**

Signature of Patient Representative

Relationship of Patient Representative to Patient

Office Representative **Date**

ASSIGNMENT OF BENEFITS

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and/or other legal entities (“payers”), which may elect or be obligated to pay, provide or distribute proceeds to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future (“condition”) to **pay directly and exclusively in the name of Victory Chiropractic** (“office”) such sums as may be owed said offices for charges incurred by me at the office relating to my condition)”charges”), with such payment to **be made exclusively in the name of Victory Chiropractic**. For the purposes of this document (herein, “assignment”), “proceeds” shall include, but not be limited to, monies/proceeds from any settlement, judgment, or verdict, as well as any monies/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, I direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the express written consent of this office.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this assignment. I further authorize and direct all payers to release to office any information regarding any coverage or benefits which I may have including, but not limited to , the amount of the 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, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Victory Chiropractic to endorse/sign my name on any and all checks listing me as a payee, which are presented to this office for payment of any account relating to me, my spouse, or any of my dependents.

I understand that I remain personally responsible for the total amounts due Victory Chiropractic for said services. If I discontinue treatment against the medical opinion/advice of my treating doctor, the balance of charges for services rendered will be due and payable immediately. If the office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **Victory Chiropractic** for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

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

By my signature be it known that I have read and fully understand the above contract.

Patient Name _____ (Print) _____

Custodian Parent/Legal Guardian _____ (Print) _____

Witness _____ (Print) _____

Date _____

In our attempt to always strive to provide our patients with the best health care they can find, we are asking you to fill out this brief survey so that we may better address your personal needs and wants. We want 2012 to be the year you are able to realize the health you deserve.

Name: _____ Date: _____ Age: _____

Address: _____ City/State/Zip: _____

Email Address: _____ Phone: _____

Dietary Summary:

How many servings of fruits do you consume per day? _____

How many servings of vegetables do you consume per day? _____

Do you consume fast food? YES NO

If YES, how often do you consume fast foods? 1-2/week 3-5/week 6+/week

Do you consume caffeine? YES NO

If YES, how often do you consume caffeine? 1-2/week 3-5/week 6+/week

Do you consume alcohol? YES NO

If YES, how often do you consume alcohol? 1-2/week 3-5/week 6+/week

Do you smoke? YES NO

Please indicate the areas of health that you want to improve:

_____ Lose Weight _____ More Energy _____ Sleep Better

_____ Improve Digestion _____ Improve General Health _____ Anti-Aging Support

If you could improve ONE thing about your health, what is your priority? Why?

Services Price List

1. New Patient Exam: \$100
This fee applies to all new patients; with and without insurance.
2. Chiropractic Treatment
With insurance: prices will vary depending on type of coverage.
cash price: \$50
3. Cold Laser: \$10
This service is not covered by insurance and is a separate charge on top of your copay or cash price.
4. Spinal Decompression: \$100 per treatment
This service is not covered by insurance and is a separate charge on top of your copay or cash price.
5. Nutritional Supplements
We offer a wide array of supplements to serve all of your health needs. These are not covered by insurance.
6. Oxygen Enhanced Exercise: \$30 per treatment
This service is not covered by insurance and is a separate charge on top of your copay or cash price.

Patient Signature: _____ Date: _____