



Date: \_\_\_\_\_

Patient #: \_\_\_\_\_

## Chiropractic Case History/Patient Information

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Fax # \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Can we send reminders via e-mail?  Yes  No Can we leave a message on your voice mail?  Yes  No

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Race: \_\_\_\_\_ Marital: M S W D  Male  Female

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Spouse/Guardian (Circle one): \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Person to reach in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Who (other than yourself) can we speak with regarding your account? \_\_\_\_\_

Who (other than yourself) can we speak with regarding your care? \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? \_\_\_\_\_

Family Medical Doctor: \_\_\_\_\_ Facility Name: \_\_\_\_\_

### PAYMENT FOR SERVICES RENDERED

As a courtesy to our patients, Partners in Health & Wellness will attempt to obtain payment from insurance carriers, and/or workers compensations plans, motor vehicle insurance companies or any other responsible parties. It is our policy to complete the insurance forms and submit to your carrier directly. We will make our best effort to secure payment from your carrier for you. However, if we do not have a resolution within 90 days, we reserve the right to secure payment from you. Be sure to check with your insurance company prior to the 90 day time frame to resolve any issue that may arise. We do expect payment at the time of service for any payment that is due by you (co-pay, deductibles, co-insurance, cash payments, etc.) whether you have insurance coverage or not.

I understand that in the event that no health insurance coverage exists, payment arrangements can be made with Partners in Health & Wellness. I, \_\_\_\_\_, authorize Partners in Health & Wellness to debit the credit card listed below, in my absence, for payment (deductibles, co-insurance, co-payments) due.

Credit Card #: \_\_\_\_\_ Expire Date: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### HISTORY OF PRESENT ILLNESS

If this is a recurrence, when was the first time you notice this problem? \_\_\_\_\_

Date this episode began or accident happened: \_\_\_\_\_

Is this due to: Auto \_\_\_ Work \_\_\_ Other \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Describe the pain: \_\_\_ Sharp \_\_\_ Dull \_\_\_ Numbness \_\_\_ Tingling \_\_\_ Aching \_\_\_ Burning \_\_\_ Stabbing

Other: \_\_\_\_\_

How frequent is the pain? \_\_\_ constant \_\_\_ daily \_\_\_ intermittent \_\_\_ night only.

What does this prevent you from doing or enjoying? \_\_\_\_\_

Is the pain improving or worsening? \_\_\_\_\_

What makes the pain better? \_\_\_\_\_ Worse? \_\_\_\_\_

Are there any other conditions or symptoms that may be related to your major symptom? \_\_\_ Yes \_\_\_ No

If yes, describe: \_\_\_\_\_

Days lost from work due to this condition : \_\_\_\_\_

### PAST MEDICAL HISTORY

Date of last physical examination: \_\_\_\_\_

If Female, is there any possibility you may be pregnant? \_\_\_ Yes \_\_\_ No

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Broken or Fractured Bones | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Circulatory Problems      | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Alcoholism      |
| <input type="checkbox"/> Rheumatoid Arthritis      | <input type="checkbox"/> Pace Maker     | <input type="checkbox"/> Drug Addiction  |
| <input type="checkbox"/> Seizures/Convulsions      | <input type="checkbox"/> Strokes        | <input type="checkbox"/> HIV Positive    |
| <input type="checkbox"/> A Congenital Disease      | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Gall Bladder    |
| <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Ruptures       | <input type="checkbox"/> Depression      |
| <input type="checkbox"/> High/Low Blood Pressure   | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Ulcers          |

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): \_\_\_\_\_

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

If yes, describe: \_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_

Do you have any allergies to any medications? \_\_\_ Yes \_\_\_ No

If yes, describe: \_\_\_\_\_

Do you have any allergies of any kind? \_\_\_ Yes \_\_\_ No

If yes, describe: \_\_\_\_\_

Please list any other health problems you have, no matter how insignificant they may be: \_\_\_\_\_

## SOCIAL HISTORY

Do you drink alcoholic beverages? \_\_\_ Yes \_\_\_ No How much per week? \_\_\_\_\_  
Do you use any tobacco products? \_\_\_ Yes \_\_\_ No If so, how much per day: \_\_\_\_\_  
Do you take vitamin supplements? \_\_\_ Yes \_\_\_ No If so, please list: \_\_\_\_\_  
Do you consume caffeine? \_\_\_ Yes \_\_\_ No If so, how much per day: \_\_\_\_\_  
Do you exercise? \_\_\_ Yes \_\_\_ No If yes, what is the frequency and type of exercise? \_\_\_\_\_  
What are your hobbies? \_\_\_\_\_  
What percentage of time during the day (at home or at your job away from home) do you spend: \_\_\_\_\_ lifting  
\_\_\_\_\_ sitting \_\_\_\_\_ bending \_\_\_\_\_ working at a computer

## Family History

Father: \_\_\_ living \_\_\_ deceased Current age if still living: \_\_\_\_\_ Cause of death and age at death if deceased: \_\_\_\_\_ (circle one)

Mother: \_\_\_ living \_\_\_ deceased Current age if still living: \_\_\_\_\_ Cause of death and age at death if deceased: \_\_\_\_\_ (circle one)

Check if applicable to you: \_\_\_\_\_ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list:  
\_\_\_\_\_

FAMILY DISEASES (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

Tuberculosis _____	Cancer _____	Mental Illness _____
Diabetes _____	Asthma _____	Heart Disease _____
Stroke _____	Kidney Disease _____	Lung Disease _____
Arthritis _____	Liver Disease _____	
Other _____		

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Our Office Policies

### Patient's Responsibility:

- Co-Pays and cash visits are due at the time service is rendered. All non-covered services, deductibles, co-insurance, etc will be billed and is due and payable once the insurance has settled. These services will be described before treatment is rendered. If your insurance company denies a claim, realize that we do our best to get the services paid, however it is ultimately your responsibility to follow-up with the insurance company and pay the balance if it is denied.
- If your insurance company requires a primary care referral, it is your responsibility to obtain such prior to services being rendered or the insurance company may not cover the visit.
- Some insurance companies require specific paperwork for authorization of treatment. These forms must be completed prior to services being rendered or the insurance company may deny your claim. We will submit the forms to the insurance company for you for approval and let you know of your coverage.
- Balances that are unsettled after 60 days may incur interest of 2.5%. This fee will be collected at time of settlement. Accounts over 90 days without prior written financial arrangements with Partners in Health and Wellness may be considered for collection action. Automatic credit cards debits can be arranged for a \$5.00 per transaction fee. Accounts released to collection action will incur a \$25.00 processing fee. A \$35.00 returned check fee will be charged for non-sufficient funds returns.
- It is customary that patient's schedule appointments prior to coming in for treatment. Walk-in and call-in patients will be seen on a work in basis. Pre-scheduled appointments will be seen first.
- No show/no call missed appointments will be charged a fee of \$25.00 if not cancelled within 24 hours. We realize that emergencies arise that may prevent you from making your appointment. Please call as soon as possible so that we can work to reschedule you at the earliest possible time.

I have read and understand the above statements and agree to adhere to these office policies.

Patient/Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

**CONSENT FOR USE OF DISCLOSURE OF HEALTH INFORMATION**

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 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.
- To another party if they are potentially responsible for the payment of your services.
- 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 you sign this consent form (164.520). We reserve the right to change of privacy practices, we will notify you in writing when you come in for treatment or by mail.

**YOUR RIGHT TO LIMIT USES OR DISCLOSURES.**

You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your 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.

**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 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.

**INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE**

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

**I have read and understand the above consent form and agree to the above terms.**

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

**AUTHORIZATION AND RELEASE**

I authorize payment of insurance benefits directly to Dr. Charles Hecht/Partners in Health & Wellness. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by Dr. Hecht, any fees for services will be immediately due and payable.

I understand and agree to allow Partners in Health to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. Further details of our (HIPAA Notice) privacy policy are available.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness