Mountain Creek Chiropractic
ABOUT THE PATIENT

Name _____ Date of Birth _____ Today's Date_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____Gender ❑ M ❑ F

Significant Other's Name _____ Kid's Names and Ages _____

Single Married Divorced Widowed Partnered

e-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes

Employer/School _____ Type of Work _____

Emergency Contact _____ Phone # _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

What makes it better? _____ Pain Scale: 1 2 3 4 5 6 7 8 9 10

What makes it worse? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

What makes it better?_____ Pain Scale: 1 2 3 4 5 6 7 8 9 10

What makes it worse? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____

How long has this been an issue? _____Pain Scale: 1 2 3 4 5 6 7 8 9 10

What makes it better?_____

What makes it worse? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional
❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening
❑ Pain radiates to_____

4. _____

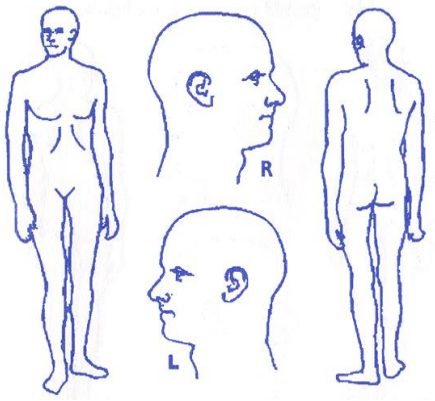
What makes it better?_____

What makes it worse? _____

How long has this been an issue? _____Pain Scale: 1 2 3 4 5 6 7 8 9 10

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional
❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening
❑ Pain radiates to_____

Please mark all areas of concern.



Are you pregnant?
❑ Yes ❑ No

5. Does your condition(s) affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

6. What type of treatment have you done for these?_____

_____

7. Results: _____

NOTES: _____

Mountain Creek Chiropractic
GENERAL HEALTH HISTORY

INJURIES/SURGERIES YOU HAVE HAD:

Description of incident **Date of incident**

Falls_____
Head Injuries_____
Broken bones_____
Dislocations_____
Surgeries_____
_____
Car Accidents_____
_____

Please check all symptoms that are a concern to you.

✕ = currently have O = have had at some point in your past ⊗ = comes and goes F = family history

___ Headaches
___ Neck Pain
___ Upper Back Pain
___ Mid Back Pain
___ Low Back Pain
___ Shoulder Pain
___ Elbow/Upper Arm Pain
___ Wrist Pain
___ Hand Pain
___ Hip Pain
___ Upper Leg Pain
___ Knee Pain
___ Lower Leg Pain
___ Ankle/Foot Pain

___ Jaw Pain
___ Joint Pain/Stiffness
___ Arthritis
___ Rheumatoid Arthritis
___ Cancer
___ Tumor
___ Asthma
___ Chronic Sinusitis
___ Irritable bowel syndrome
___ High Blood Pressure
___ Hearth Attack
___ Chest Pains
___ Stroke
___ Angina

___ Kidney Stones
___ Kidney Disorders
___ Bladder Infection
___ Painful Urination
___ Loss of Bladder Control
___ Prostate Problems
___ Abnormal Weight Gain/Loss
___ Loss of Appetite
___ Abdominal Pain
___ Sterility/Infertility
___ Ulcer
___ Hepatitis
___ Liver/Gall Bladder Disorder
___ Drug/Alcohol Dependence

___Muscular Incoordination
___ Visual Disturbances
___ Dizziness
___ Diabetes
___ Excessive Thirst
___ Frequent Urination
___ Allergies
___ Depression
___ Systemic Lupus
___ Epilepsy
___ Dermatitis/Eczema/Rash
___ HIV/AIDS
___ Smoking/Tobacco Use
___ General Fatigue

List any other conditions you have:_____

Circle if you currently have any of the following: Osteoporosis, benign bone tumors of the spine, bleeding disorders & anticoagulant therapy, radiculopathy with progressive neurological signs, acute rheumatoid arthritis, ankylosing spondylitis, acute or healed and unstable fracture/dislocation, unstable os odontoideum, spinal column malignancy, spinal column infection of the bones or joints, myelopathy or cauda equina syndrome, vertebrobasilar insufficiency syndrome, major artery aneurysm

List any medications you have taken in the last 3 months: (prescription, over-the-counter, vitamins, herbs, cigarettes, alcohol use) _____
_____

Name of Medical Doctor(s)_____

The statements made on this form are accurate to the best of my recollection and I agree to allow Dr. Davy Addison, D.C. to examine me for further evaluation:

Patient Signature: _____ **Date:** _____ **Pt ID#**:_____
Provider Signature: _____**Date:** _____
Davy Addison, D.C

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Who do you give permission to pick up your medical records?

1. _____

2. _____

3. _____

A valid driver's license will be required at the time of pickup.

_____ _____

Patient's Name Today's Date

_____ _____

Patient's / Guardian's Signature Patient's Date of Birth

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type Key: T=Treatment Records: P=Payment Information: O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

HIPAA PATIENT AUTHORIZATION FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Authorization and you are advised to do so. This authorization for release of information covers the period of healthcare from the date of your initial visit onward.

By signing this form, you authorize our use and disclosure to third parties, including but not limited to our billing and scheduling software Chirospring and our clearinghouse Office Ally, of your PHI for treatment, payment and healthcare operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Authorization but later change your mind, you have the right to revoke this Authorization by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Authorization.

The patient understands and agrees that:

The clinic has a Notice of Privacy Practices. The patient has received and had the opportunity to review this notice before signing this Authorization. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.
All of my medical records and protected health information may be disclosed or used for treatment, payment, or healthcare operations and for certain marketing purposes. The clinic will not receive any payment from a third party for marketing purposes in connection with the use of disclosure of your PHI.

The Clinic or its business affiliates may use your PHI to contact you with appointment reminders and educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or "SPAM" your personal contact information.
The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Authorization in writing at any time and all future disclosures that require the patient's prior written authorization will then cease. See the Notice of Privacy Practices for additional details.

The Clinic may not condition your treatment or payment on whether or not you sign this Authorization.

Information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

This Authorization was signed by: _____

Printed Name- Patient or Representative

_____

Signature Date

Relationship to patient
(If other than patient) _____

For Internal Use: ☐ Patient Refused to sign ☐ Patient Unable to sign for following reason_____

Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT YOUR CO-PAYS AND CO-INSURANCE RESPONSIBILITY AT TIME OF SERVICE.

For any checks that are returned for insufficient funds or auto debit credit card payments that are declined there is a $25 charge to my account that I am responsible to pay in full.

If this account is assigned to an attorney/outside agency for collection and/or suit, Mountain Creek Chiropractic shall be entitled to reasonable attorney's fees and for cost of collection.

It is the policy of this office to make you aware of any credits on your account within sixty (60) days so that you can decide whether to use it toward future treatment or receive a refund via check. If any immediate family member(s) have a patient balance said credit will be transferred to that account(s) after you are notified.

If I fail to provide any and all information necessary required by my insurance company to process my claims I will be responsible for the entire balance of my outstanding charges.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____ _____

PATIENT'S / GUARDIAN'S SIGNATURE DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Mountain Creek Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the doctor and office. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the doctor and office any and all plan documents, insurance policy and/or settlement information upon written request from the doctor and office in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the doctor and office to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the doctor and office and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with the doctor and office in any attempts by the doctor and office to pursue such claim chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with the doctor and office against such insurers and/or employee health care plan in my name but at the doctor and office's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

PATIENT'S / GUARDIAN'S SIGNATURE DATE