

HEALTH & WELLNESS CLINIC



CHIROPRACTIC

WELLNESS

PATIENT INTAKE FORM

File #: _____

Please complete the questionnaire. Your answers will help us determine how chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank You.

Name _____ Social Security # XXX - XX - _____
Address _____ City _____ State _____ Zip _____
Home Telephone _____ Work Telephone _____ Cell Phone _____
E-Mail Address _____ Birth Date _____ Age _____
Marital Status: M S W D Spouse's Name _____
Emergency Contact Person _____ Relationship _____ Phone Number _____
Referred By _____

Health Information:

Have you had previous chiropractic care? Yes__ No__ When was the last time that you were under chiropractic care?

What are your major complaints? _____

Is your condition due to an accident or job related injury? Yes__ No__ If yes, provide information in the Insurance section.

How long have you had this condition? _____ Have you had similar conditions in the past? _____

What activities aggravate your condition? - _____

Is this condition getting progressively worse? Yes__ No__ Constant ___ Comes and Goes _____

What other doctors have treated you for this condition? _____

Have you had any other personal injury or accident? Yes__ No ___ If yes, when _____

How long has it been since you really felt good? _____

List surgical operations and years: _____

Date of Last Physical Examination _____

Medications you take: Nerve Pills Pain Killers Muscle Relaxers Tranquilizer Insulin Birth Control

Blood Pressure Medication Others _____

Are you wearing: Heel Lifts Sole Lifts Inner Soles Arch Supports

Insurance Information: Group Auto Medicare Other

Name of Company _____ Policy / Claim Number _____ Group Number _____

Phone Number _____ Adjuster _____ Ext. _____

ASSIGNMENT OF BENEFITS

I hereby assign from any and all automobile/casualty insurance policies which provide medical benefits or no-fault benefits, all benefits, rights, title and interest to **M.K. Murphy, D.C., L.C.**, as Assignee, for services rendered unto me both by reason of accident or illness. This is to act as a limited assignment of my rights and benefits to the extent of the Assignee's services provided and in no way should be construed as a delegation of any duties by the Assignor to Assignee, or a delegation of any conditions precedent under the above referenced insurance policies.

_____ The Practice's Privacy Notice was made available to me and was posted

Today, I will pay by: Check Cash Zelle MC/Visa/Amex/Discover/HSA (4% fee will be added)

Patient's Signature: _____ **Date:** _____

Guardian Signature if Minor: _____ **Date:** _____

CHIROPRACTIC



WELLNESS

OFFICE POLICY

We believe that a clear definition of our office will allow you, the patient, and us to concentrate on the big issue:
REGAINING AND MAINTAINING YOUR HEALTH.

APPOINTMENT POLICY

When entering the office on any given visit, please go directly to the front desk and sign in. Please inform the receptionist of any changes that have occurred in your status: change of name, address, phone number, insurance (auto, group or Medicare), or if any injury has occurred since your last visit. We attempt to honor all appointments at the scheduled times. If you are late, you will be worked in. Occasionally, emergencies may disrupt patient flow, and we ask your patience and offer our apologies for any unforeseen circumstances that may occur. We ask that a 24-hour advance notice be given for rescheduling of appointments. At this time, there is not a fee for missed appointments however, if missing appointments becomes a habit, it may be necessary to charge for the time that could have been given to another patient. Please wear the appropriate attire: remove tie, no short skirts. This will allow for the adjustment. Please wear shoes that stay fastened to your feet, no flip flops please! Necklaces and chains are discouraged, please remove prior to appointment. **Fragrances are discouraged due to the sensitivity of others in the office.** Please no gum chewing, eating, or drinking in the office. Children are welcome, but please do not leave unattended. Please turn off cell phones.

FINANCIAL POLICY

It is our office policy that all services rendered are charged directly to you, the patient, and that you are ultimately personally responsible for all fees.

INSURANCE POLICY

Dr. Murphy does not accept assignment on group insurance, however, as a courtesy to you, our office will continue to file. Any and all payments from your insurance company will go directly to you, and payment is expected at the time services are rendered.

GROUP INSURANCE

1. Our office will qualify your insurance coverage in an effort to help you determine exactly what Chiropractic coverage is available to you under your policy.
2. All payments are due when services are rendered.
3. This office does not file secondary insurance but will be happy to provide the information necessary for you to submit.

AUTO INSURANCE - PIP

1. Our office will qualify your insurance coverage in an effort to help you determine exactly what Chiropractic coverage is available to you under your policy.
2. If your policy carries a deductible, it will be your responsibility.
3. Charges not covered by your insurance company will be your responsibility at the time of service (i.e., nutrition, orthopedic supports)

RECORDS POLICY – No copies of records/x-rays will be made until ALL account balances are paid in full.

1. If at your request, copies of records are to be sent to another health-care provider, copies will be made and you will be charged the appropriate fee per page.
2. X-rays going to another health-care provider will also be copied since they are legal documents and part of your permanent record. Your charge incurred is the appropriated fee per film.
3. Copies of records requested for consultation with another health-care provider will be made and sent to the consulting doctor at no charge to you.
4. X-rays requested for consultation by another health-care provider will be mailed or may be hand carried by you. You will sign a release for them and be responsible for their safe return.

*****There are absolutely no returns or exchanges on any PRODUCTS. No Exceptions!*****

(Initial) Dr. Murphy does not assume any responsibility/liability for services rendered without proper knowledge of the patient's history.

It is the goal of this office to provide you with the finest quality of chiropractic care available. If you have any questions regarding your healthcare or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

Print Patient Name _____

Today's date _____

Patient Signature _____

Employee Witness _____

HEALTH & WELLNESS CLINIC



CHIROPRACTIC

WELLNESS

M.K. Murphy, D.C.

INFORMED CONSENT

FILE #: _____

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

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc... Occasionally when your doctor is unavailable another clinic doctor will treat you on that day.

Stroke: stroke is the most serious problem associated with chiropractic adjustments. The most recent studies (Journal of the CCA, Vol. 35 No. 3 June 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniation: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc... Yet, occasionally chiropractic treatment will aggravate the problem. Rarely chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify probability.

Rib Fractures: Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is temporary increase in skin pain and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

~~X-Rays: I understand the clinical necessity of having X-rays taken at this time and grant permission for this procedure. In doing so, I release the doctor/clinic from responsibility for potential damage (pregnancy and non-pregnancy radiation exposure) arising from this procedure. At the present time, I am pregnant. ___ / I am not pregnant (Female patients initial) ___~~

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Nasal Specific: The nasal specific technique, which is the moving of bones and tissues of the nasal passages with the help of a small balloon (finger cot), has been used safely for at least three decades and has helped thousands of patients to breathe more efficiently through their nasal passage. This technique should not be done if you have an active infection or if you have a history of frequent and/or severe nose bleeds.

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 give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor or the office manager. When you have a full understanding, please sign and date below.

PRINT Patient Name

Today's Date

Patient Signature

HWC Employee Witness

HEALTH & WELLNESS CLINIC



CHIROPRACTIC

WELLNESS

M.K. Murphy, D.C.

AUTHORIZATION TO RELEASE, REQUEST OR OBTAIN CONFIDENTIAL INFORMATION

By signing this authorization, I authorize Health & Wellness Clinic to use and/or disclose certain protected health information (PHI), about me to or for the party or parties listed below.

I, _____, Date of Birth: _____, SSN: _____
hereby authorize Health & Wellness Clinic to [] **OBTAIN** [] **RELEASE** medical information via mail,
facsimile, or other appropriate source [] **TO** [] **FROM**:

(Person(s) or Entity(s) to receive / release requested information)

(Address) (City, State, Zip) (Phone Number) (Fax Number)

- I. The individually identifiable health information to be obtained / released is: (Please place a ✓ in appropriate space(s).)
- All Medical Records / Information (reports, phone notes, testing, therapy, billing, etc. only)
 - Entire medical chart (Specify if cover to cover requested)
 - X-Ray, Laboratory or other Diagnostic Reports
 - Nursing / Phone Notes
 - Emergency Room Records from _____ (Dates)
 - Inpatient Records from _____ (Dates)
 - Only the period of events from _____ to _____ (Dates)
 - Only information related to (specify) _____
 - Other (Specify) _____
- Therapy Notes
 - Medication List(s)
 - Financial Information

Additional Information to obtain / release: (Please place a ✓ in appropriate space(s).)

Psychological Records / Information Drug / Substance Abuse HIV results, information

- Alcohol, drug abuse information, etc. if present, has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulation (42CFR part II) prohibits making any further disclosure of it without the specific written authorization of the undersigned, or as otherwise permitted by such regulations. Additionally, further release of HIV related information is prohibited without specific authorization.

- II. The purpose or need for the disclosure of information _____.
- III. This authorization will expire on _____. (Please indicate expiration date or specific event).
(If authorization not revoked, and no expiration / event noted, it will terminate 1 year from the date of signature below.)
- IV. I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand that the revocation will not apply to protected health information (PHI) that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. My written revocation must be submitted to the Health & Wellness Clinic's Privacy Officer at the address noted on this authorization.

I understand that this practice may or may not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I further understand that the Health & Wellness Clinic may not condition treatment, payment, enrollment or eligibility for benefits on this signed authorization.

I understand that the release, use, or disclosure of my protected health information (PHI) carries with it the potential for re-disclosure by the recipient and the PHI may not be protected by the federal HIPPA privacy rule.

I understand I have the right to refuse this authorization and the facility name above is released from all legal liability that may arise from the release or receipt of the information requested.

(Signature of Patient or Legal Guardian)

(Relationship to Patient)

(Date Signed)

For Office Use Only:

Authorization received / verified by: _____ on _____.

FILE#: _____

Copy of Authorization form given to patient [] YES [] NO

Authorization fulfilled and information sent: _____

HEALTH & WELLNESS CLINIC



CHIROPRACTIC

WELLNESS

M.K. Murphy, D.C.

AUTHORIZATION TO ACCESS PATIENT'S RECORDS

Patient Name: _____ **File #:** _____

Person(s) Authorized to Access Patient's Records: _____

I do hereby authorize the abovementioned person(s) to discuss any and all of my care, treatment and procedures with Dr. Murphy and access my confidential records at any time.

PRINT NAME

SIGNATURE

DATE