

PATIENT INTRODUCTION CARD

Name (Mr. Mrs. Miss Ms.): _____ Date: _____
(Last, First, MI)

Address (Street, City, Zip): _____

Phone (Home) : _____ Phone (Work) : _____

Phone (Cell/Pager): _____ (we ask for cell/pager in case of reschedule)

Married _____ Single _____ Other _____ Age _____ Date of Birth: __/__/____

Occupation: _____ Employer: _____

Previous Chiropractic Care _____ Yes _____ No Doctor's Name _____

Name of Insurance Company _____

Major Complaint _____ Social Security Number _____

Who (or what source) referred you? _____

It is usual and customary to pay for services as rendered unless otherwise arranged.

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ No.: _____

MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?

- YES NO

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

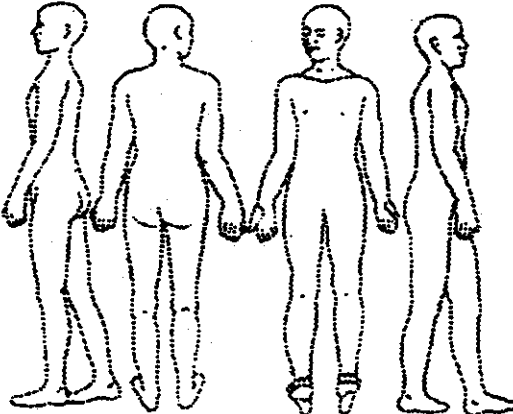
NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- _____

SYMPTOM LOCALIZATION



P ___ Pain T ___ Tender
 N ___ Numb H ___ Hypoesthesia
 S ___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

..... DO NOT WRITE BELOW THIS LINE.....

Patient Accepted? Yes No Doctor's Signature _____

AUTHORIZATION AND ASSIGNMENT

1. YOU ARE AUTHORIZED TO RELEASE ANY INFORMATION OR RECORDS YOU DEEM APPROPRIATE CONCERNING MY CONSULTATION, EXAMINATIONS, AND TREATMENT BY HILL CHIROPRACTIC CLINIC AND/OR HIS STAFF. I UNDERSTAND THAT THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE BUT NOT LIMITED TO DISEASES SUCH AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). RECORDS MAY ALSO INCLUDE INFORMATION CONCERNING DRUG/ALCOHOL USE, MENTAL HEALTH, ETC.
2. I AUTHORIZE DIRECT PAYMENT TO YOU OF ANY SUM I NOW OR HEREAFTER OWE YOU, BY MY ATTORNEY, OUT OF THE PROCEEDS OF ANY SETTLEMENT OF MY CARE, AND BY ANY INSURANCE COMPANY OBLIGATED TO MAKE PAYMENT TO ME OR YOU BASED IN WHOLE OR PART UPON CHARGES MADE FOR YOUR SERVICES.
3. IN THE EVENT ANY INSURANCE COMPANY OBLIGATED BY CONTRACTUAL AGREEMENT TO MAKE PAYMENT TO ME OR TO YOU FOR THE CHARGES MADE FOR YOUR SERVICES REFUSE TO MAKE SUCH PAYMENT UPON DEMAND BY YOU, I HEREBY ASSIGN AND TRANSFER TO YOU THE CAUSE OF ACTION THAT EXISTS IN MY FAVOR AGAINST ANY SUCH COMPANY AND AUTHORIZE YOU TO COMPROMISE, SETTLE OR OTHERWISE RESOLVE SAID CLAIM AS YOU SEE FIT.
4. I HEREBY DIRECT AND INSTRUCT MY INSURANCE COMPANY TO PAY BY CHECK AND MAIL DIRECTLY TO HILL CHIROPRACTIC CLINIC, AT 1751 W 33RD ST, SUITE 130, EDMOND OKLAHOMA, 73013 FOR SERVICES RENDERED BY ANY PHYSICIAN AND STAFF AT SAID FACILITY

SIGNATURE _____ DATE _____

CONSENT TO TREAT A MINOR

I HEREBY AUTHORIZE HILL CHIROPRACTIC CLINIC AND/OR ITS PHYSICIANS AND WHOEVER HE/SHE MAY DESIGNATE AS HIS/HER ASSISTANTS TO EXAMINE AND/OR TREAT MY CHILD WHOSE NAME IS:

NAME OF MINOR _____
SIGN OF PARENT _____ DATE _____

VERIFICATION OF NON-PREGNANCY

BY MY SIGNATURE BELOW, I DO HEREBY STATE THAT TO THE BEST OF MY KNOWLEDGE I AM NOT PREGNANT, NOR IS PREGNANCY SUSPECTED AT THIS PARTICULAR TIME.

SIGN _____ DATE _____

AUTHORIZATION TO ENDORSE CHECKS

NOW THEREFORE, UNDERSIGNED SPECIFICALLY AUTHORIZED HILL CHIROPRACTIC CLINIC AND/OR ITS DESIGNATED REPRESENTATIVE TO ENDORSE, DEPOSIT AND NEGOTIATE ALL CHECKS IN PAYMENT OF UNDERSIGNED OBLIGATIONS TO THE FACILITY AND/OR ITS STAFF.

SIGN _____ DATE _____

**PATIENT CONSENT FOR USE AND/OR
DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT
TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

_____ HEREBY STATES THAT BY SIGNING THIS CONSENT, I ACKNOWLEDGE AND AGREE AS FOLLOWS:

1. THE PRACTICE'S PRIVACY NOTICE HAS BEEN PROVIDED TO ME PRIOR TO MY SIGNING THIS CONSENT THE PRIVACY NOTICE INCLUDES A COMPLETE DESCRIPTION OF THE USES AND/OR DISCLOSURES OF MY PROTECTED HEALTH INFORMATION NECESSARY FOR THE PRACTICE TO PROVIDE TREATMENT TO ME, AND ALSO NECESSARY FOR THE PRACTICE TO OBTAIN PAYMENT FOR THAT TREATMENT AND TO CARRY OUT ITS HEALTH CARE OPERATIONS. THE PRACTICE EXPLAINED TO ME THAT THE PRIVACY NOTICE WILL BE AVAILABLE TO ME IN THE FUTURE AT MY REQUEST THE PRACTICE HAS FURTHER EXPLAINED MY RIGHT TO OBTAIN A COPY OF THE PRIVACY NOTICE PRIOR TO SIGNING THIS CONSENT AND HAS ENCOURAGED ME TO READ THE PRIVACY NOTICE CAREFULLY PRIOR TO MY SIGNING THIS CONSENT.
2. THE PRACTICE RESERVES THE RIGHT TO CHANGE IT PRIVACY PRACTICES THAT ARE DESCRIBED IN ITS PRIVACY NOTICE, IN ACCORDANCE WITH APPLICABLE LAW.
3. I UNDERSTAND THAT AND CONSENT TO THE FOLLOWING APPOINTMENT REMINDERS THAT WILL BE USED BY THE PRACTICE: 1) A POSTCARD MAILED TO ME AT THE ADDRESS PROVIDED BY ME AND 2) TELEPHONING MY HOME AND LEAVING A MESSAGE ON MY ANSWERING MACHINE OR WITH THE INDIVIDUAL ANSWERING THE PHONE.
4. THE PRACTICE MAY USE AND/OR DISCLOSE MY PHI, WHICH INCLUDES INFORMATION ABOUT MY HEATH OR CONDITION AND THE TREATMENT PROVIDED TO ME, IN ORDER FOR THE PRACTICE TO TREAT ME AND OBTAIN PAYMENT FOR THAT TREATMENT, AND AS NECESSARY FOR THE PRACTICE TO CONDUCT ITS SPECIFIC HEALTH CARE OPERATIONS.
5. I UNDERSTAND THAT I HAVE A RIGHT TO REQUEST THAT THE PRACTICE RESTRICT HOW MY PHI IS USED AND/OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT AND/OR HEALTH CARE OPERATIONS. HOWEVER, THE PRACTICE IS NOT REQUIRED TO AGREE TO ANY RESTRICTIONS THAT I HAVE REQUESTED IF THE PRACTICE AGREES TO A REQUESTED RESTRICTION, THE THEN THE RESTRICTION IS BINDING ON THE PRACTICE.
6. I UNDERSTAND THAT THIS CONSENT IS VALID FOR SEVEN YEARS. I FURTHER UNDERSTAND THAT I HAVE THE RIGHT OT REVOKE THIS CONSENT, IN WRINGING, AT ANY TIME FOR ALL FUTURE TRANSACTIONS, WITH THE UNDERSTANDING THAT ANY SUCH REVOCATION SHALL NOT APPLY TO THE EXTENT THAT THE PRACTICE HAS ALREADY TAKEN ACTION IN RELIANCE ON THE CONSENT.
7. I UNDERSTAND THAT IF I REVOKE THIS CONSENT AT ANY TIME, THE PRACTICE HAS THE RIGHT TO REFUSE TO TREAT ME.
8. I UNDERSTAND THAT IF I DO NOT SIGN THIS CONSENT EVIDENCING MY CONSENT TO THE USED AND DISCLOSURES DESCRIBED TO ME ABOVE AND CONTAINED IN THE PRIVACY NOTICE, THEN THE PRACTICE WILL NOT TREAT ME.

I HAVE READ AND UNDERSTAND THE FOREGOING NOTICE, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY FULL SATISFACTION IN A WAY THAT I CAN UNDERSTAND.

PRINTED NAME _____ **SIGNATURE** _____ **DATE** _____
OFFICE PROCEDURES

APPOINTMENT REMINDERS: YOUR CHIROPRACTOR AND MEMBERS OF THE PRACTICE STAFF MAY NEED TO USE YOU NAME ADDRESS PHONE NUMBER AND YOU CLINICAL RECORDS TO CONTACT YOU WITH APPOINTMENT REMINDERS, INFORMATION ABOUT TREATMENT ALTERNATIVES OR OTHER HEALTH RELATED INFORMATION THAT MAY BE OF INTEREST TO YOU. IF THIS CONTACT IS MADE BY PHONE AND YOU ARE NOT AVAILABLE A MESSAGE WILL BE LEFT ON YOUR ANSWERING MACHINE OR WITH THE PERSON ANSWERING THE PHONE. BY SIGHING THIS FORM YOU ARE GIVING US THE AUTHORIZATION TO CONTACT YOU WITH THESE REMINDERS AND INFORMATION AND TO LEAVE MESSAGES ON YOUR ANSWERING MACHINE OR WITH INDIVIDUALS AT YOU HOME OR PLACE OF EMPLOYMENT.

AUTHORIZATION FOR PAYMENT: YOUR CHIROPRACTOR AND MEMBERS OF THE PRACTICE STAFF MAY NEED TO DISCLOSE YOU NAME ADDRESS PHONE NUMBER BILLING INFORMATION AND YOUR CLINICAL RECORDS TO YOU INSURANCE COMPANY LAWYERS, THIRD PARTY INSURANCE COMPANY OR THE CREDIT BUREAU. THIS DISCLOSURE WILL BE MADE IF WE NEED THEIR ASSISTANCE TO RECEIVE REIMBURSEMENT FOR YOUR SERVICES OR, WE NEED THEIR ASSISTANCE BECAUSE THE PARTY RESPONSIBLE FOR REIMBURSING YOUR SERVICE HAS IMPROPERLY PROCESSED YOUR CLAIM. BY SIGNING THIS FORM YOU ARE GIVING US AUTHORIZATION TO SEND THEM THIS INFORMATION. YOU ARE ALSO GIVING THEM AUTHORIZATION TO RE DISCLOSE YOUR INFORMATION TO THE PARTY RESPONSIBLE FOR THE PAYMENT OF YOUR SERVICES, THE ASSOCIATIONS LEGAL COUNSEL AND STATE OR FEDERAL AGENCIES THAT MAY BE ASKED TO INTERCEDE ON YOU BEHALF.

THANK YOU CARDS AND REFERRAL BOARD: IF YOU REFER A FRIEND, FAMILY MEMBER OR COLLEAGUE IN TO OUR OFFICE, WE WOULD LIKE TO SEND YOU A THANK YOU CARD AND PUT YOUR NAME ON OUR REFERRAL BOARD THANKING YOU FOR SENDING HE/SHE INTO OUR OFFICE. BY SINGING THIS FORM YOU ARE GIVING US AUTHORIZATION TO SEND YOU A CARD IN THE MAIL AND PUT YOUR NAME ON OUR REFERRAL BOARD.

FINANCIAL ARRANGEMENTS: WE HAVE AN OPEN FRONT DESK AND ALL OF OUR FINANCIAL ARRANGEMENTS ARE DISCUSSED AT THE FRONT COUNTER. IF YOU FEEL THAT YOU NEED A MORE PRIVATE PLACE TO DISCUSS YOUR FINANCIAL ARRANGEMENT WE CAN ALWAYS MOVE TO THE BACK OFFICE. PLEASE NOTIFY THE OFFICE STAFF OR DOCTOR IF ARRANGEMENTS NEED TO BE MADE.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

YOU HAVE THE RIGHT TO REQUEST THAT WE DO NOT DISCLOSE YOUR HEALTH INFORMATION TO SPECIFIC INDIVIDUALS, COMPANIES, OR ORGANIZATIONS. IF YOU WOULD LIKE TO PLACE ANY RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION, PLEASE LET US KNOW IN WRITING. WE ARE NOT REQUIRED TO AGREE TO YOUR RESTRICTIONS HOWEVER, IF WE AGREE WITH YOUR RESTRICTIONS, THE RESTRICTIONS IS BINDING ON US.

I AUTHORIZE YOU TO USE OR DISCLOSE MY HEALTH INFORMATION IN THE MANNER DESCRIBED ABOVE. I AM ALSO ACKNOWLEDGING THAT I RECEIVED A COPY OF THIS AUTHORIZATION.

PATIENT NAME (PRINTED)

PATIENT SIGNATURE

DATE