

PATIENT INFORMATION

NAME: _____ SOCIAL SECURITY#: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____ BIRTHDATE: _____ AGE _____

EMAIL ADDRESS: _____

SEX: MALE FEMALE MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

EMPLOYER: _____ WORK PHONE: _____

SPOUSE'S NAME: _____ SPOUSE'S EMPLOYER: _____

IN CASE OF EMERGENCY: CONTACT: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK/CELL PHONE: _____

REFERRED BY: Insurance Website Clinic Website Mailer Friend/Family Member: _____

(Name)

INSURANCE INFORMATION (For records purposes, our office will need a copy of your insurance card.)

1. THE NAME OF YOUR HEALTH-CARE INSURANCE COMPANY IS: _____

2. ARE YOU THE PRIMARY POLICY-HOLDER?: YES NO

3. IF NO, THE NAME OF THE PRIMARY POLICY-HOLDER IS: _____

4. THE PRIMARY POLICY-HOLDER'S BIRTHDATE IS: _____

5. THE PRIMARY POLICY-HOLDER'S RELATIONSHIP TO THE PATIENT IS: _____

FINANCIAL POLICY

Your health-care insurance policy is a contract between you and your insurance company. South Charlotte Chiropractic will, as a courtesy, file your claims electronically and/or by hard-copy directly to your insurance company.

1. I, the undersigned, understand that South Charlotte Chiropractic, as a Participating Provider with my Insurance Company, agrees to the Contract Charges set by my Insurance Company. Therefore, I am financially responsible for all co-pays, co-insurance, deductibles and charges not paid by my Insurance Company and/or my Health Savings Account with regards to the Contract Charges.
2. I, the undersigned, certify that I (or my dependent) have insurance coverage with the above-listed Insurance Company and assign directly to South Charlotte Chiropractic all insurance benefits, if any, otherwise payable to me for services provided.
3. I, the undersigned, authorize South Charlotte Chiropractic to release all information required by my Insurance Company in order for South Charlotte Chiropractic to obtain payment for the services provided. I also authorize the use of my signature on all insurance claim submissions for office visits on my behalf.
4. I, the undersigned, understand that it is my responsibility to inform South Charlotte Chiropractic of any changes to my insurance coverage, address and phone information.
5. As a courtesy, payment plans are available for you and your family. If your situation requires special consideration, please let us know.
6. I, the undersigned, understand that any past due balance not paid within 90 days will be reported to the credit bureau and turned over to our attorney and/or agency for collections, and I will be responsible for all charges relating to this collections process. I also understand that a service fee of \$35.00 will be applied to my account for all returned checks due to insufficient funds.

Signature of Patient (or Legal Representative) _____ Date _____

PATIENT HEALTH QUESTIONNAIRE

SECTION 1

Reason for Today's Visit: _____

When did Your Symptoms Appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an **X** on the picture where you continue to have pain, numbness, or tingling →

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

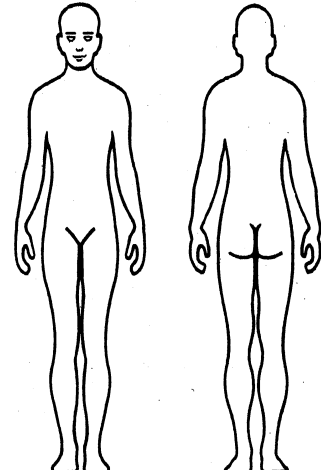
Type of Pain: Sharp Dull Throbbing Numbness Aching Burning
 Tingling Cramps Stiffness Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking
 Bending Lying Down



SECTION 2

For each of the conditions listed below, please check:

| | | | | | |
|----------------------|--|--------------------------|--|----------------------|--|
| Headaches/Migraines | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hand Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Neck Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hip/Upper Thigh Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Upper Back Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Knee/Lower Leg Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mid Back Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ankle/Foot Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Low Back Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disc | <input type="checkbox"/> Yes <input type="checkbox"/> No | Digestive Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shoulder Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Elbow/Upper Arm Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint Swelling/Stiffness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Wrist Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Sinusitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Auto Accident: Yes No If Yes, When _____
Work-Related Accident: Yes No If Yes, When _____
Other: _____

SECTION 3

ALLERGIES: _____

MEDICATIONS: _____

SURGERIES: _____

VITAMINS/HERBAL SUPPLEMENTS: _____

Signature of Patient or Legal Representative

: _____ Date: _____

ATTENTION: Female Patients

X-Ray/Pregnancy Consent

I understand that X-Rays can be hazardous to an unborn child, and that I should refuse X-Rays during any time that I may be pregnant.

My signature below certifies that to the best of my knowledge I am **NOT** pregnant and the doctor and/or his/her associates have my permission to perform a diagnostic X-Ray evaluation.

Patient Signature: _____ Date: _____

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CHIROPRACTIC CARE INFORMED CONSENT

It is important to acknowledge the difference between the health-care specialties of chiropractic, osteopathy and medicine. Chiropractic health-care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health-care services.

ANALYSIS: A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS or VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS: Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE: A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health-care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health-care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health-care regime.

POSSIBLE RISKS: As with any health-care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck.

PROBABILITY OF RISKS OCCURRING: The risks of complications due to chiropractic treatment have been described as rare. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures.

RESULTS: The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions, which do not respond to chiropractic care, may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

HEALTH-CARE SERVICES RELEASE AUTHORIZATION

I hereby authorize Dr. Natalie G. Randazzo, D.C., and Dr. Gregg Giblin, D.C. of South Charlotte Chiropractic to perform the following services: 1) Examination; 2) Radiology Evaluation; 3) Physical Therapy; 4) Manipulation; and 5) Issue Durable Medical Equipment.

I have read and fully understand the above statements and therefore I accept Chiropractic Care on this basis.

Signature of Patient or Legal Representative

Name of Patient or Legal Representative
(PLEASE PRINT)

Date

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PROTECTED HEALTH INFORMATION CONSENT FORM

Effective Date: January 1, 2011

We want you to know how your Protected Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

If you would like a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the Notice of Privacy Practices, (copies are available in the reception area).

1. The patient understands and agrees to allow this chiropractic office to use his/her PHI for the purpose of treatment, payment, health care operation and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient at this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request had been made.
5. For your security and right to privacy, each staff member has been trained in the area of patient record privacy and the Office Manager has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our Office Manager about any possible violations of these policies and procedures.
7. With this consent, South Charlotte Chiropractic, PLLC, may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and health-care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including radiology results among others.
8. With this consent, South Charlotte Chiropractic, PLLC, may mail to my home or other alternative location any items that assist this practice in carrying out treatment, payment and health-care operations, such as appointment reminder cards and patient statements.

I have read and understand how my PHI will be used and I agree to these policies and procedures.

Signature of Patient or Legal Representative

Date

Name of Patient or Legal Representative
(PLEASE PRINT)