CONFIDENTIAL PATIENT HISTORY

Today's Date: ______________

NAME: Last ____________________ First ______________ Middle Initial ____ Date of birth: ___________ Age: ____

ADDRESS: ____ City: _________________ State: _____ Zip: __________

Phone Number(s): Cell: ______________________ Primary: ______________________ Work: ____________________

Email Address: ____

Employer: ____ Occupation: ______________________________

☐ Full-time ☐ Part-time ☐ Retired ☐ Self-employed ☐ Student ☐ Not Employed ☐ Stay at home parent

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Spouse's or Emergency Contact Name: ______________________________ Phone Number: ____________________

Who may we thank for referring you to our office? ____

Have you had previous Chiropractic care? ☐ Yes ☐ No Name or Facility: ____________________________

What brings you to our office/Please provide as much detail as possible to help us better serve you...

PRIMARY COMPLAINT: ____

Date if first began: ______________ **how did it begin/what happened?** ________________________________

____

How often do you experience symptoms? ☐ **Constant 100%** ☐ **Frequent 75%** ☐ **Intermittent 50%** ☐ **Occasional 25%** ☐ Rare 10%

Type of pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Deep ☐ Stiffness ☐ Throbbing ☐ Numbness/Tingling ☐ Other

If you have numbness/tingling/where is it located? ________________ **Does the pain radiate?** ☐ Yes ☐ No

Have you ever experienced the same or similar symptoms? ☐ Yes ☐ No **When?** ______________________________

Have you been to another doctor for this problem? ☐ Yes ☐ No **Who/Where?** ______________________________

What makes the symptoms increase/worse? ____

What makes the symptoms decrease/better? ____

SECONDARY COMPLAINT: ____

Date if first began: ______________ **how did it begin/what happened?** ________________________________

____

How often do you experience symptoms? ☐ **Constant 100%** ☐ **Frequent 75%** ☐ **Intermittent 50%** ☐ **Occasional 25%** ☐ Rare 10%

Type of pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Deep ☐ Stiffness ☐ Throbbing ☐ Numbness/Tingling ☐ Other

If you have numbness/tingling/where is it located? ________________ **Does the pain radiate?** ☐ Yes ☐ No

Have you ever experienced the same or similar symptoms? ☐ Yes ☐ No **When?** ______________________________

Have you been to another doctor for this problem? ☐ Yes ☐ No **Who/Where?** ______________________________

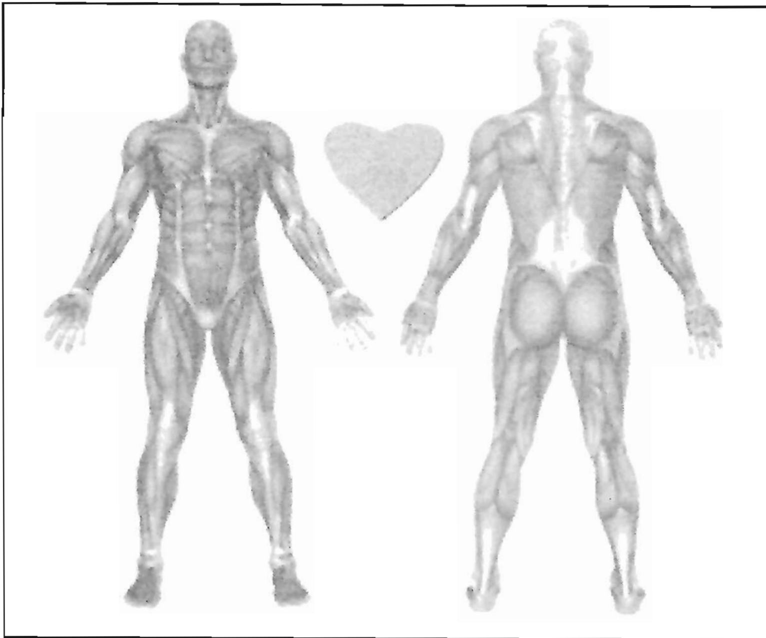
What makes the symptoms increase/worse? ____

What makes the symptoms decrease/better? ____

Please list any all surgeries, injuries, accidents, falls, etc: ____

____

____



Please mark off all areas of complaint on the Diagram with the following indictors:

AAA = ache
NNN = numbness
TTT = tingling
BBB = burning
SSS = sharp/stabbing
RRR = radiating ← ↑↓→
HHA = headaches
DDD = dull
PPP = deep

Please rate your symptoms on a scale of 0-10 (0 being no symptoms and 10 being extreme)

1 ◊◊ 2 ◊◊ 3 ◊◊ 4 ◊◊ 5 ◊◊ 6 ◊◊ 7 ◊◊ 8 ◊◊ 9 ◊◊ 10

Do you smoke? ☐ Yes ☐ No — If yes, how many packs per week? ________
If no, have you ever smoked in the past? ________ If yes, when did you quit? ________________.
Do you consume alcohol? ☐ Yes ☐ No — If yes, how many drinks per week? ________
Do you consume caffeine? ☐ Yes ☐ No — If yes, how many drinks per week? ________
Do you have a high stress level? ☐ Yes ☐ No — If yes, please explain: ________________________________
Do you exercise? ☐ Yes ☐ No — If yes, how many times per week? ______________
What type of exercise are you doing? ____

Date of Last Menstrual Cycle: ____________________ Is there any possibility that you may be pregnant? ☐ Yes ☐ No

Please check if you have had any of the following:

☐ Headaches/migraines	☐ Neck Pain	☐ Upper back pain	☐ Shoulder pain	☐ Midback pain
☐ Low back pain	☐ Arthritis	☐ Disc degeneration	☐ Arm/leg pain	☐ Jaw pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Fibromyalgia	☐ Asthma	☐ Numbness/Tingling
☐ Allergies	☐ High Cholesterol	☐ Digestive Problems	☐ Joint Pain/Stiffness	☐ Menstrual problems
☐ Pinched Nerve	☐ Loss of sleep	☐ Glaucoma	☐ Diabetes	☐ High Blood Pressure
☐ Cancer	☐ Nervousness	☐ AIDS/HIV	☐ Osteoporosis	☐ Heart Disease/Problems
☐ Paralysis	☐ Parkinson's Disease	☐ Kidney Disease	☐ PMS/Cramps	☐ Prostate problems
☐ Rheumatoid Arthritis	☐ Sciatica	☐ Sinus Pain/Problems	☐ Pacemaker	☐ Stroke
☐ Thyroid Problems	☐ Tumors/Growths	☐ Urinary Problems	☐ Vascular Disease	☐ Vision Problems
☐ Other:				

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Futhermore, I understand that The Health Doctors, P.C. will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to Dr. Nat Agrippina at The Health Doctors, P.C. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: ________________________________ **Date:** ________________

Guardian's Signature: ________________________________ **Date:** ________________

Acknowledgements

☐ **Chiropractic care**: I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

☐ **Privacy Verification**: I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties, grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office.

☐ **Permission to contact**: I grant my permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of care in this office.

☐ **Payment Verification**: I acknowledge that any health insurance I may have is an agreement between the carrier and I and that I am responsible for the payment of any covered and/or non-covered services that I may receive.

☐ **X-Ray Verification**: I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge at this time I am not pregnant and/or I understand the risks.

Date of last menstrual cycle ________________

☐ **General Verification**: To the best of my ability, the information that I have provided is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

____ ________________________

Patient's signature or guardian/responsible party ***Date***

____

Print Patient Name

THE HEALTH DOCTORS, P.C.
Chiropractic Health Care, P. C.

Nat Agrippina, B.S., D.C.
Doctor of Chiropractic

HIPAA – PRIVACY POLICY

It is the policy of our practice that all physicians staff, and any outsourced 3rd party financial, insurance or legal representatives preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide our patients the highest quality medical care possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment, and healthcare operations. Our HIPAA policy in its entirety can be obtained through our office. Please let us know if you would like to receive a copy before signing this consent.

OFFICE POLICY ON MANAGED CARE INSURERS

We are pleased to meet the needs of our patients and referring physicians by enrolling with numerous managed care insurance programs. While we are able to provide you with this service, it is extremely difficult to keep track of all the individual requirements of each plan. Even with the same insurance company the plans may differ. Providing quality holistic care for our patients is our primary concern, and we are more than willing to provide that care within your insurance contract guidelines if you let us know at each visit what those guidelines are.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently provide services, such as intersegmental traction, Ice/heat therapy, Electric Muscle Stim, Hydro Therapy, Cold laser therapy, consults, exams etc. that are not covered, we will have no choice but to bill you directly for those charges. All fees submitted and denied by your carrier will become your responsibility.

Our office will file insurance claims for you, however, office visit co pays and deductibles are payable on the day you are seen. Please remember that you are responsible for all fees, regardless of insurance coverage. Some insurance plans require prior authorization. This is your responsibility. If we do not receive the authorization in advance, payment is due at the time of service. With your cooperation, you should be able to receive all benefits offered by your insurance plan, and we will be able to concentrate on caring for your medical needs.

AUTHORIZATION – PLEASE INITIAL & SIGN BELOW

__________ I understand HIPAA and its policies

__________ I have read and understand the office policy stated above and agree to accept responsibility as described

__________ I authorize the release of medical information necessary to process a claim, to health care professionals consultation, and third party payers responsible for payment of medical and surgical benefits to The Health Doctors, P C., Nat Agrippina, B.S.D.C.

Patient's Name: ________________________________ ***DOB:*** ______________

________________________________ ______________

Patient or Responsible representative Signature ***Date***

FINANCIAL POLICY

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE
We request that 100% of each visit be paid at the time of service.

RE-EXAM POLICY
If you have not been seen in our office in the past ***3 months***, there will be re-exam fee plus and adjustment fee, and possibly an Ex-Ray fee if the doctor feels that they are necessary.

GROUP OR INDIVIDUAL INSURANCE
When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment.

******Payment will be due by you at the time of service for any non-covered services, deductibles, or co-pays.***

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
Please notify your auto insurance carrier of your visit to our office immediately. Notify our office manager immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to **SIX MONTHS** after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

ON THE JOB INJURY (WORKERS COMPENSATION)
If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, and/or a settlement has not been made in within 3 **MONTHS,** of if you suspend or terminate care, any fees and services are due immediately.

MEDICARE
We do accept assignment from Medicare. The payment is usually directly deposited, electronically to our office for the services that Medicare will cover, which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non- covered services ***(exams & X-rays).*** Our office completes and submits your claims to Medicare.

SECONDARY INSURANCE
Please inform us any secondary insurance you may have. We will assist you if you need help in filing. We do not submit to secondary insurance carriers.

I have read and understand the payment policy of the The Health Doctors, P.C.
I understand that my insurance is an arrangement between myself and my insurance company. I request The Health Doctors, P.C. prepare the customary forms so that I may obtain insurance benefits. I also understand that if my insurance does not respond in 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctor at The Health Doctors, P.C. that fees will be due and payable immediately.

Patient's signature ***(or guardian if patient is minor)***	**Printed Name**	**Date**