

PATIENT INTRODUCTION CARD

Date: _____

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

Phone (Work): _____ Phone (Cell): _____ Email: _____
(Two phone numbers required)

Address: _____ City: _____ ST: _____ Zip: _____

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

Occupation: _____ Employer: _____

Office Address: _____ Phone (Office): _____

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

Name of your Insurance Company: _____

Major Complaint: _____ Social Security No: _____

Who is your Primary Care Physician? _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged



Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Name:		Today's Date:	
What you prefer to be called:	Birth date:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Mailing Address:			
City:	State:	Zip:	
Home Phone:	Work Phone:	Cell Phone:	
Who can we thank for referring you to Dr. Dabbs?			
<input type="checkbox"/> Other: <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Clinic Location			
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			
Spouse's Name:			
Name(s) and Age(s) of Children:			
Recent Work-Related Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Recent Auto Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Previous Chiropractic Care? <input type="checkbox"/> Yes <input type="checkbox"/> No Approximate Last Visit Date:			

✓Check the following conditions that YOU have had. Circle conditions that are common to FAMILY MEMBERS

<input type="checkbox"/> AIDS	<input type="checkbox"/> Concussion	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Poor circulation
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bowel control loss	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Menstrual cramps	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Back pain	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Muscular dystrophy	<input type="checkbox"/> Serious injury
<input type="checkbox"/> Bladder trouble	<input type="checkbox"/> German Measles	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Sinus trouble
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Headaches	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Reproductive disorder	<input type="checkbox"/> Numbness	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Chest pain	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Polio	<input type="checkbox"/> Other

Have you been treated by a physician for any health condition in the last year?
 Yes No

Describe Condition _____ Date of Last Physical Exam _____

SURGICAL HISTORY:

1. _____ Date: _____
 2. _____ Date: _____
 3. _____ Date: _____

Have you ever had a metal implant?
 Yes No

ACCIDENT HISTORY:

Job
 Auto
 Other 1. _____ Date: _____
 Job
 Auto
 Other 2. _____ Date: _____
 Job
 Auto
 Other 3. _____ Date: _____

Please check reasons for pursuing chiropractic care:

- _____ I'm interested in wellness and natural health care.
- _____ I'm concerned about my health and I'm looking for answers.
- _____ I have a specific condition that concerns me.
- _____ I want to improve my immune function.
- _____ I'm continuing ongoing care from another chiropractor.
- _____ I have no idea why I'm here. Please take the time to explain to me what you do.

PLEASE DESCRIBE ANY PRESENT MAJOR COMPLAINTS:

Please Rate your symptoms (1-10, with 1 being least serious)

1. _____
2. _____
3. _____
4. _____

WHEN AND HOW OCCURRED? _____

SYMPTOMS DEVELOPED FROM: JOB RELATED INJURY AUTO ACCIDENT ACCIDENT ILLNESS
GRADUAL ONSET DATE OCCURRED: _____

SYMPTOMS HAVE PERSISTED FOR # _____ HOUR(S) _____ DAY(S) _____ WEEK(S) _____ MONTH(S) _____ YEAR(S)

HAVE YOU EVER HAD THIS BEFORE: NO YES WHEN? _____

Please check all symptoms that best describe your condition

<input checked="" type="checkbox"/>	Symptoms are worse in	<input checked="" type="checkbox"/>	Frequency of Symptoms	<input checked="" type="checkbox"/>	Quality of my pain
	Morning		Symptoms come & go		Dull Throbbing Pain
	Afternoon		Symptoms are constant		Radiating Pain
	Night		I have had this before		Numbness
			I have not had this before		Tingling
					Sharp Pain

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

If you take prescription medications, please let us know the conditions for which you take the medication and what the medications are: _____

ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD _____

What is your occupation _____

✓**Check** the following activities that **AGGRAVATE** your condition. **Circle** activities that **RELIEVE** your condition.

BENDING	COUGHING	LIFTING
REACHING	SITTING	SNEEZING
STRAINING AT STOOL	TURNING HEAD	WALKING
LYING DOWN	STANDING	SLEEPING

PLEASE ✓**CHECK** ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:

Blurred vision	Concentration loss/confusion	Light bothers eyes
Buzzing in ears	Constipation or upset stomach	Loss of balance
Cold feet	Depression	Loss of smell
Cold sweats	Insomnia	Loss of taste
Low resistance to colds	Numbness in toes	Ringing in ears
Muscle jerking	Pins and needles in arms	Shortness of breath
Numbness in fingers	Pins and needles in legs	Stiff neck

The following areas of stress can cause mis-aligned vertebrae (subluxation). Which of these stresses do you recognize from your life currently or from your childhood?

Birth Trauma	Slips/Falls
Car Accident	Sports Injuries
Physical Abuse	Poor Posture
Work Injuries	Sitting on a Wallet
Sleeping on Stomach	Extensive Computer Work
Carrying Heavy Purse/Backpack/Child	Repetitive Lifting/Bending
Driving for Many Hours	Continuous Hours Sitting/Standing
Children Stress	Career Stress
Relationship Stress	Concealed Feeling
Quick Tempered	Smoker/Second Hand Smoke
Poor Diet/Excessive Sugar	Caffeine
Artificial Sweeteners	Prescription Drugs
Over-the-Counter Drugs(ex. Tylenol/Motrin)	

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinical services that he/she deems necessary in my case; and I further authorize he/ she to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including ,but not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patients employer.

Patient Signature: _____ Date: _____



***AUTHORIZATION & ASSIGNMENT OF BENEFITS
FINANCIAL RESPONSIBILITY AGREEMENT***

Name:		DOB:	
Home Phone:	Work Phone:	Cell Phone:	
Email:			
Address:	City:	State:	Zip:
Patient's Employer/Business		Occupation:	
Payment for services will be by: <input type="checkbox"/> Self Pay <input type="checkbox"/> Family Plan <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Automobile Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> AR Kids			
If Self Pay proceed to # 2.			
Name of Primary Ins. Company:			
Name of Insured:		Insured's DOB:	
Secondary Insurance Company:			
Name of Insured:		Insured's DOB:	

I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to:
Back & Body Chiropractic

1. A copy of this can be considered as an original for insurance purposes: X _____

2. I hereby agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement. X _____

We will do our best at Back & Body Chiropractic to verify your chiropractic benefits and give you our best estimate as to what you're out of pocket expense will be. However we are not responsible when the insurance company assigns more than expected to the patient. I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family.

3. Although I have requested Back & Body Chiropractic to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill. X _____

I hereby authorize _____ to pay, by check made out and mailed directly to:
(Name of your insurance carrier)

Back & Body Chiropractic
Dr. Allan M. Dabbs
4430 Hwy 5 N., Suite 2
Bryant, AR 72022

The expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

DATE: _____, 20 ____

X _____
Signature

Address

City State Zip

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's corrections of spinal nerve interference. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

Vertebral Subluxation: Also known as spinal nerve interference. A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major inference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

All questions regarding to doctor's objective pertaining to my care in this office have been answered to my complete satisfactions. I therefore accept chiropractic care on this basis.

(Signature)

(Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I may not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period:

(Signature)

(Date)



HIPAA Notice of Privacy Practices

Back & Body Chiropractic

THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital administration.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of health care students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to health care students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include ; as Required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners: Funeral Directors, and Organ Donation. Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human services to investigate or determine our compliance with the requirements of section 164.500

Other permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Patient Signature _____ Date Signed _____