Crossroads Family Chiropractic
New Patient History

PLEASE PRINT CLEARLY

Date: _____ Patient Number: _____

Name: _____ Preferred Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Occupation: _____ Employer: _____

DOB: _____ Age: _____ SSN (of responsible party if minor): _____ Gender: ☐ M ☐ F

Marital Status: _____ Number of Children: _____

Preferred language: ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian

☐ Other _____

Race: ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander

☐ Black or African American ☐ Hispanic or Latino ☐ Decline to Answer ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Insurance Carrier, Policy Holder's Name and DOB:_____

Are you seeing another healthcare provider for other problems or health conditions? ☐ Yes ☐ No

If yes, please list the problem(s), date(s) began, and treating provider: _____

_____

Have you been diagnosed with: ☐ Hypertension ☐ Diabetes (☐ Type I ☐ Type II) If yes, include date and provider seen:_____

Current drugs (prescription & non-prescription), including dosage and frequency: _____

_____ ☐ None

Allergies: ☐ Food ☐ Environmental ☐ Medication Type of Allergy and Reaction _____

_____

Past surgeries and approximate dates: _____

Family History of: ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Back problems ☐ Scoliosis/Back Curvature

☐ Other _____

Smoking Status: ☐ Never ☐ Past Smoker, date quit: _____ ☐ Current Smoker, daily amount: _____

Alcohol consumption: ☐ None ☐ Casual ☐ Moderate ☐ Heavy _____ servings/ day week

Caffeine consumption: ☐ None ☐ < 3 drinks/day ☐ 3-6 drinks/day ☐ > 6 drinks/day

Non-medical drug use: ☐ None ☐ Recreational User ☐ Addiction

Exercise: ☐ Never ☐ Daily ☐ Weekly

Are you wearing: ☐ Heel lifts ☐ Arch supports ☐ Foot Orthotics

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Major Complaint(s): _____

Date Began: _____ How did condition begin? _____

Other doctors seen: _____

Is it getting worse? ☐ Yes ☐ No Have you lost work/school days? ☐ Yes ☐ No How many? _____

Have you had a similar condition before? ☐ Yes ☐ No If yes, when? _____

Is this injury related to: ☐ work accident ☐ auto accident ☐ other accident _____

Please mark any that apply with (O) for past and (X) for present condition – any that have never applied, leave blank.

A
- ____ Fractured Bones
- ____ Auto Accidents
  - ____ 0-1 yr ago
  - ____ 1-5 yrs ago
  - ____ More than 5 yrs
- ____ Other accidents/Falls
- ____ Knocked unconscious
- ____ Back Curvature
- ____ Mental/Emotional Disorders
- ____ Arthritis
- ____ Diabetes
- ____ Swollen/Painful Joint
- ____ Convulsions/Epilepsy
- ____ Skin problems
- ____ Itching
- ____ Bruise easily
- ____ Cancer
- ____ Frequent Colds/Flu
- ____ Ringing in ears (R/L)
- ____ Hearing loss (R/L)
- ____ Fainting
- ____ Loss of balance
- ____ Blurred or double vision (R/L)
- ____ Upper back pain or stiffness (R/L)
- ____ Mid back pain or stiffness (R/L)
- ____ Low back pain or stiffness (R/L)
- ____ Numbness, tingling,or pain in buttocks, thighs, legs, knees, feet, or toes (R/L)
- ____ Knee pain (R/L)
- ____ Pain with cough, sneeze, or strain at stools
- ____ Hip pain (R/L)
- ____ Foot trouble (R/L)
- ____ _____

B
- ____ Nervous
- ____ Tension
- ____ Depressed
- ____ Irritable
- ____ Anemia
- ____ Excess Sweating
- ____ Tremors
- ____ Light bothers eyes
- ____ Light headed upon rising
- ____ Allergy
- ____ Sinus Problems
- ____ Under stress
- ____ Crave sweets or salt
- ____ Eating disorders

C
- ____ Trouble sleeping
- ____ Trouble concentrating
- ____ Loss of memory
- ____ Learning disability

E
- ____ Chest pain
- ____ Asthma
- ____ Lung problems
- ____ Difficult breathing
- ____ Wheezing
- ____ Heart Problems
- ____ High or low blood pressure
- ____ Stroke
- ____ Varicose veins
- ____ Liver trouble
- ____ Gall bladder trouble

F
- ____ Digestive problems
- ____ Excessive gas
- ____ Belching/Bloating after meals
- ____ Heartburn
- ____ Ulcers
- ____ Diarrhea/constipation
- ____ Colon trouble
- ____ Hemorrhoids

- ____ Mistake sidedness (L/R)
- ____ Stutter
- ____ Dyslexia
- ____ Mood Changes
- ____ Lose Temper Easily

D
- ____ Headache
- ____ Neck pain or stiff (R/L)
- ____ Numbness, tingling, pain in arms, hands, fingers
- ____ Jaw pain or click (TMJ)
- ____ Head seems too heavy
- ____ Head/Shoulders tired
- ____ Difficulty in excessive (Standing, Walking, Sitting, Riding, Bending, Lifting, Twisting, Household duties)
- ____ Shoulder Pain (R/L)
- ____ Dizziness
- ____ Prostate problems
- ____ Impotence

G
- ____ Kidney trouble
- ____ Kidney stones
- ____ Frequent urination
- ____ Breast lumps, soreness, discharge
- ____ Discharge
- ____ Menstrual problems/PMS
- ____ Painful urination
- ____ Menopausal problems
- ____ Pregnant (NOW)
- ____ Bedwetting
- ____ Ear infections
- ____ Hepatitis
- ____ Venereal disease
- ____ AIDS/ARC
- ____ Eating disorder
- _____

Printed Name: _____ File: _____

Signature (or parent/guardian of minor): _____ Date: _____

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and Crossroads Family Chiropractic accepts a patient for such care, it is essential for both parties to be working toward the same objective. It is important that each patient understand both the objective and the method for attaining it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment. You may make the decision whether or not to undergo chiropractic treatment after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and may recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care at CFC have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____	_____
Printed Name	**Signature (or parent/guardian of minor)**	Date	File #

PATIENTS UNDER 18 YEARS OF AGE ONLY | Consent to Evaluate and Adjust a Minor Child

Patient Name(s): _____

I certify that as the parent or legal guardian of the above named patient(s), I have read and fully understand the above Informed Consent. By my signature below, I consent for the patient(s) to receive chiropractic care.

The patient(s) ☐ can ☐ cannot schedule and attend appointments without me present.

_____	_____	_____
Parent/Guardian Name	**Signature**	Date

FEMALE PATIENTS ONLY | Statement of Non-Pregnancy

This is to certify that to the best of my knowledge I am not pregnant and the above-mentioned doctor and his 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 cycle _____ **Signature** _____

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Financial Policy Agreement

Crossroads Family Chiropractic is dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance or you have insurance coverage which we determine should cover the service in full. If you choose not to provide your social security number, you will be required to make payment prior to treatment. If insured, copays and deductible or coinsurance amounts are due at time of service. We accept Visa, MasterCard, Discover, American Express, checks and cash. Any unpaid 60-day balance which is not part of a payment plan, shall incur a monthly late fee of $25.00.

2. Keep in mind that your insurance policy is a contract between you and your insurance company and as the patient, you are ultimately responsible for payment for services rendered. As a service to you, we will file your claim with your insurance company. By your signature below, you authorize payment to be made directly to the clinic or doctor under which the services are billed.

3. Not all insurance plans cover all services. We will attempt to determine your insurance benefits prior to treatment, but the information provided to us regarding eligibility and benefits is not always 100% accurate. In the event that your insurance plan determines a service to be 'not covered' or the claim remains unpaid for a period of 120 days or more, you will be responsible for the complete charge. *If a claim is not paid as expected and we are unable to resolve the discrepancy with your insurance company, you will be responsible for any additional balance according to the Explanation of Benefits from your insurance plan.* Payment is due upon receipt of a statement from our office. In the event that insurance payment reflects a lesser patient responsibility than what you have paid at time of service, you may be refunded the excess amount or you may choose to keep the credit on your account and use it for future services. Credit may also be transferred to other family members receiving care.

4. Only after exhausting our own internal attempts for payment will we send a delinquent account to our collection agency. You will then be responsible for all collection fees incurred in collecting the balance (30% of the outstanding balance due). Should this happen, you may be discharged from our practice. Acceptance back into the practice would only be considered after your account is paid in full.

5. We offer discounted prepay packages and payment plans for patients without insurance or for patients who choose not to have their insurance billed for their care. Please inquire at the front desk for details.

6. If you consented for a minor to schedule and receive treatment without you present, you agree either to a) send cash or a check for payment in full on the date of service; or b) provide a credit card number to be kept on file and charged at the time of service. *Any services which are not paid at the time of service will not be eligible for any time of service discounts and will be billed to you at the full fee schedule rates.*

I have read and understand the Financial Policy Agreement of Crossroads Family Chiropractic.
I agree to be bound by its terms. I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

_____ _____

Printed Name File #

_____ _____

Signature (or parent/guardian of minor) Date

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. This form is a "friendly" version of the privacy practices. A more complete text is available for your review upon request.

A brief explanation: There are rules and restrictions regarding who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services (www.hhs.gov).

Crossroads Family Chiropractic has adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. All patient information, office notes, and other records are stored electronically and are only accessible to office staff. You agree to the normal procedures utilized within the office for the handling of patient records, PHI and other documents or information.
2. It is the policy of this office to contact patients regarding missed appointments and to remind them of upcoming massage appointments. We may do this by telephone or email. We may send you other communications informing you of changes to office policy by U.S. mail.
3. This practice utilizes a number of vendors in the operation of business. These vendors may have access to PHI but must agree, in writing, to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents that may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

Printed Name File number

_____ _____

Signature (or parent/guardian of minor) Date

Continued on next page…

Protected Health Information Release

At times we may need to contact you by to discuss an appointment, health information, or financial information. In order to protect your privacy, we need to know how you would like to be contacted by our office staff or doctors.

Home number _____
□ Use this number first
□ Leave a call back number only

Work number _____
Extension _____
□ Use this number first
□ Leave a call back number only

Cell number _____
□ Use this number first
□ Leave a call back number only
□ Text messaging can be used for massage reminders, notifications
Cell carrier*: _____
**due to network restrictions, texts cannot be sent to T-Mobile or Metro PCS customers.*

Email _____
□ Use this method first

DISCLOSURE OF INFORMATION

Please choose an option:

□ **Information *may be shared* with the following person(s):**

Name of Person	Relationship to Patient
_____	_____
_____	_____
_____	_____

Information you do not wish to be shared (please be specific): _____
_____

□ **I choose not to authorize disclosure to anyone. *(Please initial the following statements)***

I understand that by choosing not to authorize disclosure to anyone, this means that:
Only I am authorized to confirm, schedule, or change appointments. _____
Only I am authorized to receive account information or make payments on my account. _____
No information regarding treatment or even confirmation of status as a patient will be disclosed to any individual, regardless of personal relationship. _____

EXPIRATION

**If no option is chosen, no expiration will be applied.*

Please choose an option:

□ **This authorization expires on** _____ /_____ /_____

□ **NO EXPIRATION** (unless revoked or terminated by the patient or the patient's personal representative)

_____ _____
Patient Name File number

_____ _____ _____
Signature of Patient or Representative Relationship to Patient Date