PATIENT CONFIDENTAL INFORMATION

Patient Name _____ _____ _____
First Middle Last

Social Security # _____ _____ Male _____ Female Birthdate ____/____/____ Age _____

Address _____ City _____ State _____ Zip _____-_____

Home Phone _____ Cell Phone _____ Email _____

Circle One: Minor Single Married Divorced Widowed Separated

Race (circle one): African American American Indian Asian Caucasian/White Decline Other_____

Ethnicity (circle one): Hispanic Non-Hispanic Decline

If over the age of 13 are you a smoker? (circle one): Never Former Current Every Day Current Some Day

Preferred Language (circle one): English Spanish Other_____

Patient or Parent's Employer _____ Work Phone _____

Employer's Address _____ City _____ State _____ Zip _____

Spouse or Parent's name _____ Employer _____ Cell phone _____

Who referred you to our Clinic? _____(Example-Name, Phone Book, Internet)

Is this an accident? _____Yes _____No Auto (date) _____ Work Injury (date) _____

Have you contacted an attorney? _____Yes _____No If so, name of attorney _____

Emergency Contact Information _____ Home Phone _____
Someone NOT living with you

Relationship _____ Cell Phone _____

Responsible Party for this account _____Relationship to patient _____

Address _____ Phone _____ Cell _____

Birthdate _____ Social Security _____ Employer _____

Is this person a patient already at our clinic _____ Yes _____ No

INSURANCE INFORMATION

Insurance Name _____ Name of Policy Holder _____

Policy Number _____ Group Number _____ Policy Holder Birthdate ___/___/___

**Are you covered by another Insurance besides the one above? _____ YES _____ NO If so please fill out the following:

Insurance Name _____ Name of Policy Holder _____

Policy Number _____ Group Number _____ Policy Holder Birthdate ___/___/___

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ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage (health, accident or Worker's compensation coverage) and assign directly to *SOUTHRIDGE CHIROPRACTIC PC* all insurance benefits, if any, otherwise I am responsible for services rendered. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, my insurance carrier or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by the organization. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I understand I am financially responsible for all charges and the bill whether it is paid by the insurance or if the claims submitted are denied. I authorize the use of my signature on all insurance submissions. The above-named clinic/ or doctors associated with this clinic may use my health care information and may disclose such information to my insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end if I give written notice otherwise this will be in effect indefinitely.

Please sign here stating that you have read the above paragraph and accept the terms above:

Print _____ Sign _____ Date ____/____/_____

Signature of Patient, Guardian or Personal Representative

Clinical summaries will show the treating physician, vitals, medications and allergies that are listed in your file. If you would like this at each visit please provide your email. If not, please check the box below and sign. Thank you!

☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank because of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date:_____

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize the Doctors at Southridge Chiropractic Clinic and whomever they may designate as their assistants to administer chiropractic care as deemed necessary to my _____

Relationship of child

_____

Name of child

Date:_____

Signed:_____

Name: _____ **PATIENT CONDITION**

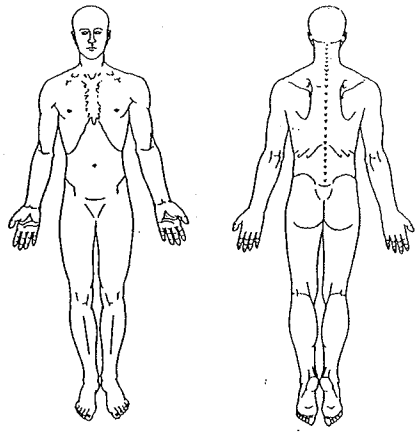
Date_____ Height _____ Weight _____

Reason for visit _____

When did your symptoms appear? _____

Was there an accident or injury? If so, when?_____

Is this condition getting worse _____Yes _____ No _____ Staying the Same



Mark an X on the picture where you 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 ____Shooting
____Burning ____Tingling ____Cramps ____Stiffness ____Swelling ____Other

How often do you have this pain? _____

Is it constant or does it come or go? _____ Does it interfere with your ____ Sleep ____ Daily Routine
____ Work ____ Recreation

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

What treatment have you received for your condition? ____ Medications ____Surgery ____Physical Therapy
____ Chiropractic Services ____ Other

Name of other doctor(s) who have treated you for your condition? _____

Date of Last: Physical exam _____ Spinal X-ray _____ Blood Test _____
Spinal Exam _____ Chest X-ray _____ Urine Test _____
Dental Exam _____ MRI, CT-Scan, Bone Scan _____

Circle any of the following if you have had:

AIDS/HIV
Alcoholism
Allergy Shots
Anemia
Anorexia
Appendicitis
Arthritis
Asthma
Bleeding Disorders
Breast Lump
Bronchitis
Bulimia
Cancer
Cataracts
Chemical Dependency
Chicken Pox
Diabetes
Emphysema
Epilepsy
Fractures
Glaucoma
Goiter
Gonorrhea
Gout
Heart Disease
Hepatitis
Hernia
Herniated Disk
Herpes
High Blood Pressure
Kidney Disease
Liver Disease
Measles
Migraine Headaches
Miscarriage
Mononucleosis
Multiple Sclerosis
Mumps
Osteoporosis
Pacemaker
Parkinson's Disease
Pinched Nerve
Pneumonia
Polio
Prostate Problems
Prosthesis
Psychiatric Care
Rheumatoid Arthritis
Rheumatic Fever
Scarlet Fever
Sexually Transmitted Disease
Stroke
Suicide Attempt
Thyroid Problems
Tonsillitis
Tuberculosis
Tumors, Growths
Typhoid Fever
Ulcers
Vaginal Infections
Whooping Cough
Other _____
_____

Exercise
None
Moderate
Daily
Heavy

Work Activity
Sitting
Standing
Light Labor
Heavy Labor

Habits
Smoking
Alcohol
Coffee/Caffeine Drinks
High Stress Level

Packs/Day _____
Drinks/Week _____
Cups/ Day _____
Reason _____

-Continued on Back -

Are you pregnant? _____YES _____ NO Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Motor Vehicle Accidents		
Work Injuries		

Are you currently taking any medications? ☐ I'm not taking any medications.

(If so, please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies? ☐ I have no known drug allergies.

Medication Name	Reaction	Onset Date	Additional Comments

Do you have any Family History of the following:

Cancer	F	M	B	S	Key (Immediate family members only) F= Father M= Mother B= Brother S= Sister
Alcoholism	F	M	B	S	
Diabetes	F	M	B	S	
Heart Disease	F	M	B	S	
High blood pressure	F	M	B	S	
Other (please specify):					

For office use only: BP____/_____

Southridge Chiropractic PC
425 S 7th St
Bismarck, North Dakota 58504
PH: 701-258-8388

Consent to use PHI

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Southridge Chiropractic PC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.

_____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

FINANCIAL POLICY
SOUTHRIDGE CHIROPRACTIC CLINIC

Please initial correct line:

_____**CASH** – I am aware that I am totally responsible for all health care bills incurred on my account. I will pay them each visit with cash, check or credit card.

_____**MEDICARE** – I understand that this office is participating provider for Medicare. It will bill and receive payment from Medicare for covered services as long as a spinal problem exists and is demonstrated by *exam* or x-ray. Only spinal adjustments are covered and extremities (wrist, elbow, knee, ankle or feet) are NOT covered by Medicare. An initial exam is mandatory prior to receiving care. Non-covered services include exam, re-exams, consultation fees, x-rays, acupuncture, covered services (in certain cases), and unapproved services not covered by my insurance.

_____ **INSURANCE** - I understand that my insurance policy is a contract between my company and me. This office, as a courtesy to me, will submit claims in a timely manner, respond to any written request from my insurance company, and allow up to 30 days for them to pay their portion of my bill. If this payment is not received within 30 days of service, I understand it is my responsibility to contact my insurance company to see why payment has not been issued. I am totally responsible for the balance at that time. It is also my responsibility to request pre-authorization from my insurance company for treatment, according to my policy.

_____**WORKER'S COMPENSATION** – I am aware that this office will bill my worker's compensation insurance for my work related injury. I will submit any correspondence received from my insurance company to this office. If my company denies liability for any reason, I understand that I am personally responsible for all health care bills accrued at this office.

_____**PERSONAL INJURY** – I understand that this office will bill my personal injury insurance company for treatment related to my injury. I am also aware that if this insurance company terminates or does not pay my health care bills that I, personally, am responsible for those bills. At that time, this office will submit claims to my general health insurance company if I have such a policy.

_____**MEDICAID** - I understand that this office will bill the medical assistance program for covered services which include 20 spinal manipulations of the spine. This program does not cover any other areas but the spine. I am aware that non-covered services such as physiotherapy, vitamins, acupuncture, massage, supplies and supports are my responsibility of these at the time of service. I am aware that if this program does not cover my services for any reason that I, myself am responsible.

I UNDERSTAND THAT THERE IS A TIME FRAME TO FILE ALL INSURANCE CLAIMS. IT IS MY RESPONSIBILITY TO CONTACT THIS OFFICE WITH ANY NEW OR CHANGING INFORMATION ON MY INSURANCE POLICY. IF I DO NOT CONTACT OR GIVE THE CORRECT INFORMATION TO THIS OFFICE, IT IS MY RESPONSIBILITY FOR THE BILL IN FULL.

I UNDERSTAND THAT ANY SUPPLIES, SUPPORTS OR NUTRITIONAL SUPPLEMENTS MUST BE PAID FOR AT THE TIME OF PURCHASE REGARDLESS OF THE INSURANCE INDICATED ABOVE.

I HAVE READ THE ABOVE AND UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT ACCORDING TO THE ABOVE INDICATED POLICY THAT I HAVE INITIALED.

_____	_____	_____
PRINT NAME	PATIENT'S SIGNATURE	DATE