Creech Chiropractic

Confidential Health Resume

Welcome to our practice! Please clearly complete all questions. Thank you.

Personal History

Last Name: _______________________________ First Name: _________________ MI: ______

Address: ______________________________City:____________________________State/Zip code: ____________________ Social Security #: _______________________

Date of Birth: _______________ Age: ____________ Marital Status: _______________

Home Phone: ______________________ Work/Cell Phone: _________________________

Email address: ____________________________ Employer: ______________________

Spouse Name: ____________________ Work Place/Number: _______________________

Name and ages of children: ____

Health Insurance & Policy Information

Policy Holder's Name: ______________________DO B: ___________Relation__________

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

Emergency Contact Name & Number: ___________________________Relationship________

Physician's Name _____________________ Telephone #: ___________ City: __________

Current Health Condition

Reason for today's appointment? ____

When did this condition begin? _______________________Have you had this before? **Yes** **No**

Is this condition/injury due to a (**circle one**): Sports Injury? Job-related Injury? Home-related? Auto Accident Injury? Fall? Other? (please explain):

____

Previous Chiropractic Care? **Yes** **No** Treated for the same problem as above? **Yes** **No**

Name of Previous Chiropractor: ________________________City/State: ______________

Date of last adjustment? _______________________ Frequency of visits? _______________

Rate your dietary & water intake on a weekly basis: Excellent Good Average Poor Bad

Food Allergies and/or Sensitivities: ____

Frequency of Exercise (circle one) : **< 4 times/month** **1-2 times/week** **3-4 times/wk** **5+ times /wk**

CREECH CHIROPRACTIC

Supplements currently taking: ____

Medications currently taking: ____

Prior Surgeries and/or Hospitalizations (list procedures/years performed): ________________

____

____

Please List **5 most recent Major Injuries, Spinal Traumas, Falls or Accidents** (Date & Extent of Injury):

____

____

____

Wellness Commitment

At Creech Chiropractic, we are dedicated toward achieving the goal of total, lasting health for our patients. Based on a scale of 10%-100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness.

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

I have read and completed the information, and it is accurate to the best of my knowledge. I understand that Creech Chiropractic *may or* ***may not*** be an in-network provider for my insurance plan. Creech Chiropractic will seek to verify my specific benefits as quickly as possible and advise me of such. Furthermore, I understand that this office will prepare any necessary reports and forms to ensure an efficient collections process from my insurance company, and the authorized amount will be paid directly to Creech Chiropractic and credited to my account upon receipt. However, I clearly understand and agree that I am **personally and immediately** responsible for payment if/when my insurance company denies payment for any previously provided services.

____

Patient Signature Date

____

Guardian's Signature (Authorizing Care for a Minor) Date

Please Check the Pertinent Boxes Below.

Condition or Symptom	Constantly Or Frequently (50-100%)	Sometimes/ Occasionally (0- 50%)	Family History Of Condition?
Headaches			
Migraines			
Neck Pain			
Shoulder Pain			
Arm/Hand Pain			
Mid Back Pain			
Low Back Pain			
Hip Pain			
Leg/Foot Pain			
Disc Problems			
Arthritis			
Other Joint Pain			
Numbness			
Joint Swelling			
Dizziness			
Nausea			
Weakness			
Fatigue			
Nervousness			
Insomnia			
Heart Problems			
Vision Changes			
Nose Bleeds			
Ringing in Ears			
Earaches			
Hearing Loss			
Cough			
Chest Pains			
Female Problems			
Allergies			
Asthma			
Cancer			
Osteoporosis			
Diabetes			
Hypoglycemia			
Digestive Problems			
Heartburn			
Urinary Problems			
Frequent Colds			
Skin Conditions			
Sciatica			

FEMALES: Is there a possibility of pregnancy? ❑ Y ❑ N

Use The Letters Below To Indicate The Type And Location Of Your Symptoms:
A=Ache B=Burning

I hereby authorize Creech Chiropractic to examin me, including X-rays (if indicated by my exam), an to release my records to anyone I designate. I further authorize treatment deemed necessary by the findings, and wish all my chiropractic records to be held in strict confidence and not be released to anyone withou my written consent.

By signing below, I certify the accuracy of my family, medical and/or accident history and furthe certify that I present to Dr. Creech's office for evaluation and treatment of a health-related condition and for no other purpose.

Signature of Patient or Guardian

Date

First Day's Fees Are Due and Payable at the Time of Servic Unless Insurance Benefits are Verified Beforehand.

CREECH CHIROPRACTIC

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

________________________________ Printed Name

________________________________ Authorized Provider Representative

________________________________ Signature

________________________________ Date

________________________________ Date

CREECH CHIROPRACTIC

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Dr. Creech and the members of the practice staff at Creech Chiropractic Center may need to use your name, address, phone number, or your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health-related information that may be of interest to you. If this contact is made by phone, and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health-related information at any time (§164.524).

This notice is effective as of ______________________. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

______________________	______________________
Patient Printed Name	Authorized Provider Representative
______________________	______________________
Signature	Date
______________________	
Date	
______________________	______________________
Personal Representative Printed	Personal Representative Signature

____

Automobile Accident History

Patient Name_________________________ **Today's Date**______________ **Date of Injury**______________

Your Vehicle: (year, make, model)____

Estimated speed of your vehicle at impact? ______________mph Time of Day ________ AM/PM

Name of person driving the vehicle you were in? _________________ _________________

Where were you seated in vehicle? ____

Road conditions at time of accident (wet, dry, etc.) ________________________________

At the moment of impact, was your vehicle, O Stopped O Slowing O Accelerating?

Which part of your vehicle was hit? O Front O Side O Rear O Other________________

Which way was your head pointed at impact? O Straight O Right O Left O Up O Down

Were you wearing a seatbelt? O Yes O No *If yes*, what type? _____________________

Was the seat back or headrest altered at all by the accident? O Yes O No

Did your airbag deploy? O Yes O No *If Yes,* where were you struck? _______________________

Other Vehicle: (year, make, model) _________________________ estimated speed at impact___________

What part of the other person's vehicle hit your car? O Front O Side O Rear O Other____________

At moment of impact, was the other vehicle: O Stopped O Slowing O Accelerating?

During the Accident:

If driving, your hand position: _________________ Did you strike any part of the vehicle? O Yes O No

If yes please describe ____

Did vehicle strike any objects after the crash? O Yes O No if yes describe_______________________

Were you aware or surprised by the impending collision?______________________________________

Were you wearing a hat or glasses? O Yes O No *If yes,* were they still on after crash? O Yes O No

Did you lose consciousness (black out) after impact? O Yes How long? __________ O No

Did you experience a flash of light or explosion in your head? O Yes O No

After the Accident:

Did you become: O Confused O Disoriented O Light-headed O Dizzy O Nauseated O Blurry Vision

From the list above which symptoms do you still experience? _____________________________

Did the police come to the accident scene? O Yes O No Was a report issued? O Yes O No

Hospital

Did you go to the hospital? O Yes O No *If yes, please complete the following questions.*

Name and city of hospital__________________ How did you get to the hospital? _________________

Were X-rays taken? O Yes O No *If yes,* which region was x-rayed? ________ ___________________

What other treatment was given? O Cervical collar O Ice pack O Medications O ______ __ ______

O Follow up instructions given ____

In the space below, please describe, to the best of your knowledge, what happened during this accident.

Please turn over and complete the back side

Patient Name____________________________ Today's Date______________ Date of Injury______________

Complaints stemming from your Accident

***Chief* Complaint**: ______________________________ Date when symptom first appeared ____________
Describe your chief complaint (sharp, dull, achy, etc.) ____
Does the pain radiate? YES NO *If yes, where does it radiate?* _______________________________
What makes symptoms increase?____
What makes symptoms decrease? ____
Is the pain? Constant (100%) Frequent (75%) Intermittent (50%) Occasional (25%) Rare (10%)
Rate your pain from 0-10 (10 being severe). 0 --------------------------- 5 -----------------------------10

***Second* Complaint**: ____________________________ Date when symptom first appeared_____________
Describe your complaint (sharp, dull, achy, etc.) ____
Does the pain radiate? YES NO *If yes, where does it radiate?* _______________________________
What makes symptoms increase? ____
What makes symptoms decrease? ____
Is the pain? Constant (100%) Frequent (75%) Intermittent (50%) Occasional (25%) Rare (10%)
Rate your pain from 0-10 (10 being severe). 0 --------------------------- 5 -----------------------------10

***Third* Complaint**: __________________________ Date when symptom first appeared ________________
Describe your complaint (sharp, dull, achy, etc.) ____
Does the pain radiate? YES NO *If yes, where does it radiate?* _______________________________
What makes symptoms increase? ____
What makes symptoms decrease? ____
Is the pain? Constant (100%) Frequent (75%) Intermittent (50%) Occasional (25%) Rare (10%)
Rate your pain from 0-10 (10 being severe). 0 --------------------------- 5 -----------------------------10

***Other* Complaints**: _________________________ Date when symptom first appeared________________
Describe your complaint (sharp, dull, achy, etc.) ____
Does the pain radiate? YES NO *If yes, where does it radiate?* _______________________________
What makes symptoms increase? ____
What makes symptoms decrease? ____
Is the pain? Constant (100%) Frequent (75%) Intermittent (50%) Occasional (25%) Rare (10%)
Rate your pain from 0-10 (10 being severe). 0 --------------------------- 5 -----------------------------10

X-RAY CONFIRMATION—FEMALE PATIENTS ONLY
This is to confirm that this office has advised me that X-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographs if necessary.

____ ________________________
Signed Date

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

____
____
Patient Signature Date

CREECH CHIROPRACTIC

OUR OFFICE POLICY

RE: PERSONAL INJURY CASES

If you have been involved in an auto accident, or related injury, and have insurance that covers medical expenses at 100% or an attorney representing you, we will gladly accept your case with the following regulations:

1. If you have an attorney, notify us as soon as possible and ask him or her, to send us a letter of representation. A bill will be sent to the attorney for you. It is our policy to have this information within 5 working days from your initial presentation to our office.

2. If you do not have attorney, you will need to ask the insurance adjustor handling your claim to contact our office and provide all information for billing the insurance company. **NO BILLS, OR COPIES OF BILLS, WILL BE GIVEN TO YOU OR THE INSURANCE COMPANY UNTIL YOUR ADJUSTOR HAS CALLED US AND GIVEN AN INDICATION THAT THEY WILL DO EVERYTHING POSSIBLE TO PROTECT THE DOCTOR'S INTEREST**.

Once your case has been settled and all Chiropractic bills have been paid, if an overpayment exists on your account (due to having more than one insurance filed) we will forward that overpayment to you.

By signing below I am stating that I have read the above and to understand that I will not be presented with copies of bills until the proper procedures have been followed.

Date:____________________ Signature:___________________________________

Date:____________________ Witnessed:___________________________________

CREECH CHIROPRACTIC

ASSIGNMENT OF PROCEEDS, LIEN AND AUTHORIZATION

I hereby authorize and direct any and all insurance carriers, attorneys and agencies, governmental, departments, companies, individuals, and/or legal entities ("payers"), which may elect to be obligated to pay, provide or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") to pay directly and exclusively in the name of Creech Chiropractic Center ("CCC" or "office") such sums as may be owing to CCC for charges incurred by me at the Office relating to my condition ("charged"), with such payment to be made exclusively in the name of Creech Chiropractic Center. I further grant a lien to CCC with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein, "Assignment and Lien"), "benefits" shall include, but not be limited to, proceeds from any settlement, judgment, or verdict as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

In the event that I retain one or more attorneys to represent me in this matter who are not located in North Carolina, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letters of protection cannot be revoked or modified without the expressed written consent of this Office.

I authorize this Office to release any information regarding my treatment or pertinent to my case's to all payers as defined above to facilitate collection under this Agreement and Lien. I further authorize and direct all payers to release to CCC any information regarding any coverage or benefits which I may have including, but not limited to the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims, I hereby direct this Office to file a copy of this Assignment and Lien, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize CCC to endorse/sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize CCC to apply a credit balance incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents regardless of these other charges being related to my condition.

I understand that I remain personally responsible for the total amounts due for their services. This Assignment and Lien does not constitute any consideration for this Office to await payment and it may demand payments from me immediately upon rending services which is optional. If this Office must take any action to collect on an outstanding balance on my account, I will be responsible for payment and will reimburse CCC for all cost of such collection efforts, including but not limited to, all costs and all attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of CCC and myself. I hereby revoke any previously signed authorizations, whether the extent the terms of those authorizations conflict with the terms of this Assignment and Lien.

Patient Name (please print)____

Patient Signature:________________________________ Date:________________________________

Name of Custodial Parent or Legal Guardian (please print)______________________________________

Parent/Guardian Signature_________________________ Date:________________________________