ACCOUNT # : ______________
(office use only)

NAME: ______________________________ DATE: ____________

MAILING ADDRESS: ______________________________
CITY: ______________________ STATE: ________ ZIP: ________

SOCIAL SECURITY NUMBER (to verify ins. benefits) : ______________________

PHONE NUMBERS: Home: ________________ Cell: ________________

EMAIL ADDRESS: ______________________________

I CONSENT TO APPOINTMENT REMINDERS VIA EMAIL AND/OR TEXT: YES ☐ NO ☐

DATE OF BIRTH: ______________ AGE: __________ GENDER: Male ☐ Female ☐

MARITAL STATUS: Child Single Married Divorced Widowed

PREFERRED LANGUAGE: ______________________________

RACE (CIRCLE ONE): American Indian or Alaska Native Black or African American
White or Caucasian Native Hawaiian or Pacific Islander
Asian I Decline to Answer

SMOKING STATUS (CIRCLE ONE): Current Every Day Smoker Current Some Day Smoker
Former Smoker Never Smoked

ETHNICITY (CIRCLE ONE): Hispanic or Latino Not Hispanic or Latino I Decline to Answer

TELL US HOW YOU HEARD ABOUT US!

My Employer: ________________ My Friend: ________________
Facebook: ________________ Email: ________________
Newspaper: ________________ Event: ________________
I just live in the area: ____________ Other: ________________

EMPLOYMENT STATUS: Full Time Part Time Student
Homemaker Retired Unemployed
Disabled (if so, since when?________)

OCCUPATION: ______________________________
EMPLOYER: ______________________________

EMERGENCY CONTACT NAME: ______________________________
RELATIONSHIP: ________________ THEIR PHONE #: ________________

HEALTH INFORMATION

ARE YOUR COMPLAINTS DUE TO AN AUTO ACCIDENT OR WORKPLACE INJURY? YES ☐ NO ☐

Purpose of this appointment: ______________________________

Other Doctors seen for this condition: ______________________________

When did this condition begin? ______________________________

Please list all accidents or hospitalizations *within the last year*: ______________________________

____

Previous Chiropractic: Yes ☐ No ☐ Doctor Name & Date of last visit: ______________________________

***Check any of the following illnesses or conditions that apply to YOU*:**

- □ Allergies
- □ Arthritis
- □ Asthma
- □ Back Surgery
- □ Cancer
- □ Diabetes
- □ Heart Disease
- □ High Blood Pressure
- □ Irritable Bowel Syndrome
- □ Lung Disease
- □ Neck Surgery
- □ Previously Broken Bones ______________
- □ Other ______________

Family Health History

If any, specify who the following conditions apply to (Mother, Father, Siblings, or Children):

- □ Allergies
- □ Arthritis
- □ Asthma
- □ Cancer
- □ Diabetes
- □ Heart Disease
- □ High Blood Pressure
- □ Irritable Bowel Syndrome
- □ Lung Disease
- □ Other ______________

MEDICATIONS

Are you currently taking any medications? YES ☐ NO ☐ (INCLUDE ANY OVER THE COUNTER MEDS)

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

Do you have any medication allergies? YES ☐ NO ☐ (IF YES, PLEASE DOCUMENT BELOW)

Medication Name	Reaction	Onset Date	Additional Comments

PRINT NAME: ______________________________

PATIENT / PARENT SIGNATURE: ______________________________ **DATE:** ______________

CURRENT PERSONAL HEALTH

Please check (☑) any of the following symptoms you have or have had in the past 6 months.

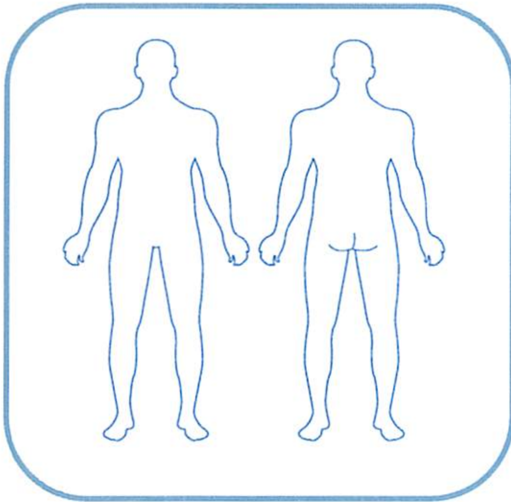
- □ Neck Pain
- □ Shoulder Pain
- □ Upper/Mid Back Pain
- □ Low Back Pain
- □ Hip Pain
- □ Buttock Pain
- □ Jaw Pain

- □ Arm Pain
- □ Hand/Wrist Pain
- □ Knee Pain
- □ Foot Pain
- □ Ankle/Leg Swelling
- □ Leg Pain
- □ Joint Pain/Stiffness
- □ Cold/Tingling Extremities
- □ Numbness in Extremities

- □ Ear Aches/Infections
- □ Chest Pain
- □ Heart Problems
- □ Constipation
- □ Bladder Trouble

- □ Allergies
- □ High/Low Blood Pressure
- □ Headaches
- □ Migraines
- □ Dizziness/Light Headedness
- □ Heartburn/Indigestion
- □ Vomiting/Diarrhea
- □ Loss of Sleep
- □ Shortness of Breath
- □ Walking Trouble
- □ Excessive Weight Loss/Gain
- □ Sexual Dysfunction

Mark an area of pain or discomfort



CONSENT TO TREATMENT: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications. The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from taking a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million, to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

PRINT NAME: ______________________________

PATIENT / PARENT SIGNATURE: ______________________ **DATE:** ____________

CONSENT TO TREATMENT OF CHILD / MINOR

IF CHILD IS NOT YOUR BIOLOGICAL CHILD, WE MUST HAVE GUARDIANSHIP DOCUMENTATION BEFORE TREAMENT

I hereby authorize the doctor in the office and whomever they may designate as assistants to administer chiropractic care as deemed necessary to my son / daughter. Parent or Legal Guardian must be present during first visit, first treatment, and to make financial agreements. Legal documentation is required for those who may have the authority to consent to the treatment of a child / minor, such as a legal guardian or family member.

____________	____________	____________	______
PATIENT'S NAME	PRINT PARENT / GUARDIAN NAME	PARENT / GUARDIAN SIGNATURE	DATE

FINANCIAL RESPONSIBILITY

Please read the following statements and check off all that apply to you and your insurance type and/or your financial responsibilities and then sign at the bottom of the page.

☐ **SELF-PAYING PATIENTS / CASH**

Any and all services performed in our office will be explained to you prior to the services being rendered.
I understand, by signing this form, all charges I have been notified of and agreed upon will be my personal responsibility. I also understand that my balance shall not exceed $300.

☐ **PATIENTS WITH INSURANCE**

You are responsible for deductibles, copays, non-covered services, coinsurance and items considered "not medically necessary" by your insurance company.
Please pay co-payment amounts as services are rendered. The remaining balance should be taken care of within one (1) month of notice from your insurance company. Balances due shall not exceed $300.
If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the front desk staff to make other arrangements.
I authorize, by signing below, the release of any medical information necessary to process claims on my behalf. I also request payment of government benefits either to myself or the party who accepts assignment in the service described on the Health Insurance 1500 claims form.
I understand and agree that health and accident policies are an agreement between an insurance carrier and me. We accept assignment as a courtesy to you. We are not a mediator between you and your insurance company. We will not enter into a dispute with your insurance company. Furthermore, I understand that Campbellsburg Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Campbellsburg Chiropractic will be credited to your account upon receipt. However, I clearly understand that all services rendered to me are charged to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or professional services rendered to me will be immediately due and payable.
I am also aware that at any time I have a question regarding my insurance coverage or payment; I will ask to speak to the finance department.
PATIENTS WITH MEDICARE: Our office will submit your Medicare charges to Medicare and your secondary Insurance.
You are responsible for deductibles, copays and any non-covered services.

PLEASE USE YOUR INSURANCE CARDS TO FILL OUT THE FOLLOWING FIELDS THAT APPLY

PRIMARY INSURANCE INFORMATION:

Insurance Name: ______________________ **ID#:** ______________________
Name of Insured: ______________________ **Group #:** ______________________
Relationship to patient: ______________________ **Ins. Phone No.:** ______________________
Insured Social Sec. #: ______________________ **Insured D.O.B.:** ______________________
Insured Address: ____

SECONDARY INSURANCE INFORMATION **(if applicable):**

Insurance Name: ______________________ ID#: ______________________
Name of Insured: ______________________ Group #: ______________________
Relationship to patient: ______________________ Insurance Phone No.: ______________________
Insured Social Sec. #: ______________________ Insured Date of Birth: ______________________
Insured Address: ____

INSURANCE RESPONSIBILITY ACKNOWLEDGEMENT.
PLEASE SIGN AND DATE BELOW, NO MATTER IF YOU DO OR DO NOT HAVE INSURANCE.

PRINT NAME: ____

PATIENT / PARENT SIGNATURE: ______________________ **DATE:** ______________________

HIPAA PRIVACY

AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing. Campbellsburg Chiropractic will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization, you acknowledge and agree that some of our treatments are performed at Campbellsburg Chiropractic in an open setting where incidental disclosures may occur. You also agree that Campbellsburg Chiropractic may use or disclose your personal health information for referral to other health care providers with your permission, any billing or collection activities or proceedings, leaving messages on answering machines or making phone calls to you regarding scheduling of appointments, your health benefit coverage and related discussion of your care, or phone or mail notifications of any internal office promotions.

Please identify the family members, friends or other persons who are or will be involved in your care or payment for health care and with whom you authorize us to share your protected health information:

Name	**Relationship to you**	**List information to be shared**
______________________	_____________	______________________
______________________	_____________	______________________
______________________	_____________	______________________

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Campbellsburg Chiropractic's NOTICE OF PRIVACY PRACTICES containing a description of your rights, and permitted uses and disclosures, under HIPAA. While Campbellsburg Chiropractic has reserved the right to change the terms of its NOTICE OF PRIVACY PRACTICES, copies of the NOTICE, as amended, are available from Campbellsburg Chiropractic, at our office or by sending a written request with return address to Campbellsburg Chiropractic 8172 Main Street P.O. Box 293 Campbellsburg, KY 40011, Attn: Office Manager. You have the right to revoke this authorization, in writing, at any time, except to the extent that Campbellsburg Chiropractic, has taken action in reliance on it. A revocation is effective upon receipt by Campbellsburg Chiropractic, of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Campbellsburg Chiropractic, or (d) two (2) years from the date this authorization was executed.
By signing this authorization, you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

ACKNOWLEDGED AND AGREED TO BY:

PATIENT NAME: ____ **DATE:** ____________

PATIENT SIGNATURE: ___________________________________

OR

PRINT NAME OF PARENT/GUARDIAN OF MINOR: ______________________________________

PARENT/GUARDIAN SIGNATURE: ____

RELATIONSHIP: ____