Optimum Health Chiropractic

Catherine L. Hoag, D.C.

Today's Date: ____/____/____ Z: _____

Chiropractic Intake

Name: _____ DOB: ___/___/___ Age:_____
First MI Last

Preferred Name:_____

Address_____ City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____

1. Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Last 4 of Social Security #_____ # Children _____ Ages: _____

Employer_____ Occupation: _____

Work Address: _____City:_____ State:_____ Zip:_____

Spouse/Parent Name: _____ Phone #:_____

Spouse/Parent Employer:_____ Work #:_____

Emergency Contact:_____ Phone#:_____

Referred by: _____

Your Primary Care Physician _____ Last Exam_____

Do you have health insurance? ☐ Yes ☐ No Insurance Company:_____

Primary Insured's Name:_____ Insured's DOB: _____/_____/_____

Reason For Your Visit

☐ Pain Symptoms ☐ Wellness Visit ☐ Auto Accident ☐ Work Related Injury

☐ Sports Injury ☐ Other Injury:_____

Date of Injury / Onset of Symptoms:_____

Have you ever received Chiropractic Care? Yes No If yes, when? _____
Name of most recent Chiropractor: _____

6521 Creedmoor Rd., Suite 102, Raleigh, NC 27613
919-845-7279 Fax 919-870-9499

Optimum Health Chiropractic
Dr. Catherine Hoag

Consent Form

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 obtain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. 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 disease or infirmity.

Vertebral Subluxation: 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 a 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 or unusual 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 interference 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.
(print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.
I therefore accept chiropractic care on this basis.

_____ _____
(Signature) **(Date)**

Consent to evaluate and adjust a minor child:
I, _____ being the patient 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 am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.
Date of last menstrual period: _____

_____ _____
(Signature) **(Date)**

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Financial Policy

Thank you for choosing us as your chiropractic provider. We are committed to providing you the best possible care, and we are pleased to discuss our professional fees with you at any time. The following is a statement of our Financial Policy which we require you to read and sign prior to any medical services.

- FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE. NO EXCEPTIONS. IF YOU DO NOT HAVE YOUR CO-PAYMENT, YOU WIL NEED TO RESCHEDULE AND YOU WILL BE ASSESSED A $50.00 CANCELLATION FEE.
- ALL PAYMENTS WILL CE COLLECTED UPON CHECKING IN FOR YOUR SCHEDULE APPOINTMENT.
- WE ACCEPT CASH, PERSONAL CHEECKS, VISA AND MASTERCARD.

INSURANCE

- If we are a participating provider with your insurance plan you are responsible for all co-payments, deductibles and any non-covered services at the time of service. Deductibles and an estimated co-insurance must be taken care of prior to service. As a courtesy we will file insurance claims with most insurance carriers, provided you have supplied us with the proper information.
- If we are NOT a participating provider with your insurance plan you are responsible for full payment at time of service. If you need to file your own insurance our office will provide you with the proper documentation.

MINOR PATIENTS

The adult parent or guardian accompanying the minor is responsible for payment of the minor patients' account regardless of who the insurance policy holder is. For unaccompanied minors non-emergency treatment can be denied until a parent or guardian is present or we have written permission for treatment and payment of the account period.

WORKMAN'S COMPENSATION

All workmen's compensation claims must be verified in writing by the employer. Verbal or telephone verifications are not acceptable. If you have seen another physical for the same compliant and authorization for a change of physical must be verified on your company's form.

PERSONAL INJURY WITH ATTORNEY

If you are being represented by an attorney or a third party payer, we will provide you with the proper information to file your claim. You are responsible for full payment to our office at the time services are rendered.

AUTOMOBILE ACCIDENT

If you were in an automobile accident and you have "Med-Pay" automobile insurance our office will provide you with the proper documentation to file the claims. It will be your responsibility to file the claims. If you have health insurance we will file a claim for all professional services received.

MISSED APPOINTMENTS

Failure to give 24 hour notice of cancellation of your appointment will result in a $50.00 fee billed directly to you. We will not bill your insurance company for this amount. You will be responsible for prompt payment of this fee prior to being seen at your next scheduled visit.

FORMS

We will be happy to complete any medical forms. Payment of $10.00 is required prior to completion of each form(s). Please allow 7-10 business days for your form to be completed.

COLLECTIONS

If you account balance becomes past due and is sent to an outside collection agency, you will be responsible for any additional fees incurred. This will occur if balances are more than 90 days past due.
All monthly statements are due and payable in full upon receipt.
All returned checks are subject to a $25.00 service fee.

Thank you for understanding the necessity of our financial policy. If you need to make special payment arrangements please bring this to our attention prior to being examined. Please sign your name with the date below to indicate your understanding of our policy and your willingness to abide by it.

_____ _____

Signature of Patient or Guardian Date

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Broken Appointment Policy

It is the policy of this office to charge a $50.00 fee for appointments which are not canceled prior to their scheduled time.

After Hours Weekend Visit Policy

There will be an additional charge of $27.00 for after hours and weekend appointments.

I, the undersigned, have read and understand the above stated policy.

Signature Print Name Date

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL 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 describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our 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, pay your health care bills, to support the operations 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 or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or 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 admission.

Healthcare Operations: We may 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 medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school 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 included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you 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.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

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I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I agree to pay my estimated co-pay at the time services are rendered, including my deductibles, and further understand that the estimated co-pay is neither a guarantee of payment by insurance company, nor necessarily an accurate reflection of my actual co-pay as determined by my insurance company upon processing my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time upon request of this office, I will immediately pay the balance on my account. I further understand and agree that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees. I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney(s) who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers. I have read, understood, and agree to the foregoing. The information I have provided is true and complete, to the best of my knowledge.

Patient's Signature:_____

Date:_____/_____/_____

NEW PATIENT HISTORY FORM

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

5. Social and Occupational History:

A. Job description:

_____

B. Work schedule:

_____

C. Recreational activities:

_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

Your Medical History: (Check all that apply) (Y: Yourself F: Family Member)

Y F	Y F	Y F	Y F
☐ ☐ Fatigue	☐ ☐ Dizziness / Vertigo	☐ ☐ Fainting	☐ ☐ Cold Hands
☐ ☐ Cold Feet	☐ ☐ Hand Tremors	☐ ☐ Nausea	☐ ☐ Diarrhea
☐ ☐ Constipation	☐ ☐ Varicose Veins	☐ ☐ Stroke	☐ ☐ Difficulty Breathing
☐ ☐ Coughing Blood	☐ ☐ Bleeding	☐ ☐ Sweats	☐ ☐ Pregnancy
☐ ☐ Prostate Problems	☐ ☐ Heart Attack	☐ ☐ Circulatory Problems	☐ ☐ High Blood Pressure
☐ ☐ Low Blood Pressure	☐ ☐ Ulcers	☐ ☐ Heart Problems	☐ ☐ Pacemaker
☐ ☐ Diabetes	☐ ☐ Alzheimer's	☐ ☐ Gallbladder Problems	☐ ☐ Digestive Problems
☐ ☐ Eczema	☐ ☐ Convulsions	☐ ☐ Tumors	☐ ☐ Seizures
☐ ☐ Epilepsy	☐ ☐ Tinnitus	☐ ☐ Headaches	☐ ☐ Migraines
☐ ☐ Eye/ Vision Problems	☐ ☐ Ear/hearing problems	☐ ☐ Arthritis	☐ ☐ Osteoarthritis
☐ ☐ Rheumatoid Arthritis	☐ ☐ Osteoporosis	☐ ☐ HIV/AIDS	☐ ☐ Congenital Disease
☐ ☐ Ruptures	☐ ☐ Disc Disorder	☐ ☐ Speech Difficulty	☐ ☐ Loss of Memory
☐ ☐ Confusion	☐ ☐ Nervousness	☐ ☐ Anxiety	☐ ☐ Mental Illness
☐ ☐ Irritability	☐ ☐ Tension	☐ ☐ Depression	☐ ☐ Insomnia
☐ ☐ Eating Disorder	☐ ☐ Alcoholism	☐ ☐ Drug Addiction	☐ ☐ Scoliosis
☐ ☐ Tonsillitis	☐ ☐ Kidney Disorder	☐ ☐ Gout	☐ ☐ Neuralgia
☐ ☐ Chills	☐ ☐ Earache	☐ ☐ Sciatica	☐ ☐ Amputation
☐ ☐ Vomiting	☐ ☐ Hemorrhoids	☐ ☐ Bursitis	☐ ☐ COPD
☐ ☐ Broken / Fractured Bones	☐ ☐ Neuro-Muscular Disease	☐ ☐ Loss of Bladder Control	☐ ☐ Loss of Bowel Control
☐ ☐ Cancer:	☐ ☐ Other:	☐ ☐ Other:	☐ ☐ Other:

Which Activities are difficult due to your Pain / Discomfort?

☐ Sleeping	☐ Walking	☐ Standing	☐ Sitting	☐ Running
☐ Climbing	☐ Bathing	☐ Showering	☐ Dressing	☐ Shoes
☐ Toileting	☐ Cleaning	☐ Self Care	☐ Family Care	☐ Child Care
☐ Home Care	☐ Driving	☐ Gardening	☐ Working	☐ Lifting
☐ Desk Work	☐ Traveling	☐ School	☐ Concentrating	☐ Other:

1. Reasons for seeking chiropractic care:

Primary reason:

Secondary reason:

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

3. Past Health History:

A. Previous illnesses you've had in your life:

B. Previous Injury or Trauma:

Have you ever broken any bones? Which?

C. Allergies:

D. Medications:

Medication Reason for taking

E. Surgeries:

Date Type of Surgery

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome

4. Family Health History:

Associated health problems of relatives:

Deaths in immediate family:
Cause of parents or siblings death Age at death

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