QUICKCHARTS PATIENT CASE HISTORY

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Occupation: _____

Date of Birth: _____ Social Security #: _____-_____-_____ Gender: Male - Female

Marital Status: M S W D P Primary Care Physician_____Would you like us to send a report? Y N

List any **Allergies**:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs ☐ Latex ☐ Molds ☐ Penicillin ☐ Ragweed/Pollen

☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye ☐ Other: _____

List any **Surgeries**:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist ☐ Other: _____

List **ALL Past Medical History** conditions:

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain ☐ Depression

☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting ☐ Fatigue ☐ Foot Pain

☐ Genetic Spinal Condition ☐ Hand Pain ☐ Headaches ☐ Hearing Problems ☐ Hepatitis ☐ High Blood Pressure

☐ Hip Pain ☐ HIV ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain ☐ Menstrual Problems ☐ Mid-Back Pain

☐ Minor Heart Problem ☐ Multiple Sclerosis ☐ Neck Pain ☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's

☐ Polio ☐ Prostate Problems ☐ Shoulder Pain ☐ Significant Weight Change ☐ Spinal Cord Injury ☐ Sprain/Strain

☐ Stroke/Heart Attack ☐ Other: _____

List **Medications** you are taking:

1._____ 4._____

2._____ 5._____

3._____ 6._____

List your **Family History**:

☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Genetic Spinal Condition

☐ High Blood Pressure ☐ Heart Problems ☐ Multiple Sclerosis ☐ Neurological Problems ☐ Parkinson's ☐ Polio

☐ Prostate Problems ☐ Stroke/Heart Attack ☐ Other: _____

Have you had any auto or other accidents? ☐ No ☐ Yes

Describe: _____

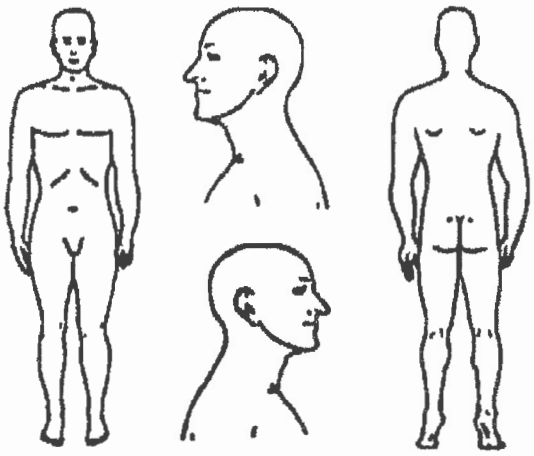
Date of last physical examination: _____ Do you smoke? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes - how many per day? _____

Do you drink caffeine? ☐ No ☐ Yes - how many per day? _____

Do you exercise? ☐ No ☐ Yes (what forms and how often): _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce symptoms
- ☐ Resume normal activity level

What is your major complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES - NO

Location of pain: Left Right Center Both Sides

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Intensity: Minimum Mild Moderate Severe Unbearable

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Describe the nature of your symptoms: ☐ Burning ☐ Dull ☐ Numb ☐ Radiating Pain (_____)

☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling

☐ Other_____

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What is your Second complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES - NO

Location of pain: Left Right Center Both Sides

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Intensity: Minimum Mild Moderate Severe Unbearable

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling

☐Other_____

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Have you ever had chiropractic care? _____

When? _____ Why? _____

Where? _____

Were X-rays taken? _____

When was your last adjustment? _____

OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.

2. This office may make payment plan arrangements on an individual basis with a credit/debit card arrangement on file. Any such plan or arrangement will be discussed during your financial care plan visit.

INSURANCE

1. We do not accept assignment, but as a courtesy to you; we will bill your insurance company within 24 hours of your visit. You are responsible for your entire bill. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.

2. Any services not covered or coverage reductions by your insurance will be your responsibility.

3. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

4. If the patient is referred to another specialist or discontinues care for any reason, their account balance is due and payment in full is required immediately.

5. If you have questions concerning this or any other matter, please speak with the front desk prior to seeing the Doctor.

6. Patients may be refused services based on the following criteria: Any patient not on pre-arranged payment plans with an account balance of $250 or greater must pay for that days services at the time they are rendered. This patient must also make a payment arrangement for the outstanding account balance.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient's Signature Date

PROTECTING YOUR CONFIDENTIAL HEALTH INFORMATION IS IMPORTANT TO US

This notice describes how health information about you may be used and disclosed and how you get access to this information. Please read carefully.

OUR PROMISE!

It is our desire to communicate to you that we are taking a new Federal (HIPAA-health care laws) seriously.

The most significant variable that has motivated the federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information.
We have put into writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about theses policies and procedures which we developed to make sure your information will not be shared with anyone who does not require it.
We will use and communicate your HEALTH INFORMATION only for the purpose of providing your treatment and obtaining payment from your insurance company . Your health care information will not be used for other purposes unless we have asked for and been voluntary given your written permission.

HOW YOUR HEALTH INFORMATION MAY BE USED

TO PROVIDE TREATMENT
We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, physician and business office staff. In addition, we may share your health information with referring physicians, clinical laboratories, or other health care personnel providing you treatment. .

ABUSE OR NEGLECT
We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

PUBLIC HEALTH AND NATIONAL SECURITY
We may be required to disclose to federal officials, law enforcement or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of a epidemic or the understanding of new side effects of a drug treatment or medical device.

PATIENTS RIGHTS

This new law is careful to describe that you have the following rights related to your health information.

RESTRICTIONS

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privacy with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

INSPECT AND COPY YOUR INFORMATION

You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to change you a reasonable fee to duplicate and assemble your copy.

AMEND YOUR HEALTH INFORMATION

You have the right to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

DOCUMENTATION OF HEALTH INFORMATION

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health care operations. Our documentations procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

REQUEST A PAPER COPY OF THIS NOTICE

You have the right to obtain a copy of this notice of privacy practices directly from our office at any time. Stop by or give us a call and we will mail a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this notice of our privacy practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. If we change our privacy practices we will be sure all of patients receive a copy of the revised notice.

You have the right to express complaints to us or to the secretary of health and human services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please
Let us know of your concerns or complaints in writing.

ACKNOWLEGMENT *of* RECIEPT *of the*

NOTICE of PRIVACY PRACTICES *of*

Mountain View Chiropractic P.C.

herein after referred to as *the Clinic*.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by ***the Clinic*** to ensure the privacy of my personal health information. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (*please print*) **Date**

_____

Signature of Patient, Parent, Legal Guardian or Patient's Legal Representative

Please list below the names and your relationship of people to whom you authorize *the Clinic* to release your private health information:

Print Name **Relationship**

_____

_____

This form will be placed in the patient's chart and maintained for six years.

CONSENT FOR TREATMENT
AND
AUTHORIZATION TO PERFORM X-RAYS

Date _____ Time _____ AM PM

I have been informed by Dr. Lisa Beighle that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness).

I authorize Dr. Lisa Beighle to perform such radiographic examination necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present problem (or illness).

Signed: _____

Witness: _____

To the best of my knowledge I am NOT pregnant and the above named Doctor has by permission to x-ray me for diagnostic interpretation.

Signed: _____

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you. I herby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and action in my name as your see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit, However, it is understood that until a reasonable effort has been make to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due. I personally owe and agree to pay to you.

4. In addition to the above, I herby waive the statute of limitations on collection and/or recovery in this State of TN.

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization for Assignment will be in continual effort until revoked by both parties.

_____ Date _____ Patient/Insured Signature

RECORDS RELEASE

To _____, I hereby authorize you to release to _____ any information including the diagnosis and records of treatment or examination rendered to me or all care during the period from _____ to _____.

_____ Date _____ Patient/Insured Signature

_____ Date _____ Staff Signature

RELEASE FROM CARE

I, _____ hereby understand that Dr. _____ is releasing me from care, for my accident dated _____, and that I have reached | | pre-accident status or | | maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

Patient Signature _____ Date _____ Staff Signature _____