LIFE CHIROPRACTIC OF OLNEY
REGISTRATION FORM
(Please Print)

Today's Date:	Email:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle :	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security No.:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:		Home Phone no.: ( )
City	State / ZIP Code	Cell Phone No.: ( )
Occupation:	Employer:	Work Phone No.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Internet ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your photo ID & insurance card to the receptionist)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Name of Primary/Auto Insurance (if applicable): Policy/Claim No: Group No.:

Subscriber's name, if different:	Subscriber's S.S. no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Policy No.:	Group No.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone No.: ( )	Cell Phone No.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Life Chiropractic of Olney or insurance company to release any information required toprocess my claims.

_____ _____

Patient/Guardian Signature *Date*

Name: _____

Date: _____

LIFE CHIROPRACTIC OF OLNEY

INTAKE FORM

CHIEF COMPLAINT

Please list, in order of importance, your chief complaint(s) and mark below:

1. _____
2. _____
3. _____

Cause, if known: _____

Is this due to a recent Auto or Work Accident Yes No (If yes, please answer the questions below)

Type: Auto Work

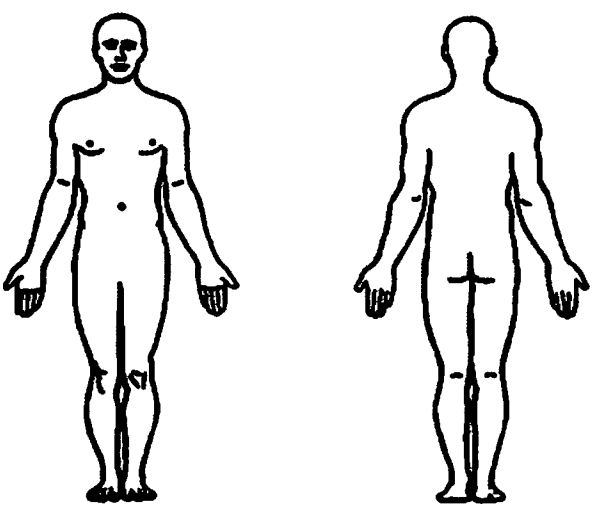
Date/Time of Accident: _____

Location (including State): _____

Were you the driver – or – passenger? If passenger, please provide the name of the driver :

_____

Please mark below the location of your chief complaints:



Name: _____

Date: _____

Radiating:

Yes _____ No _____ If so, where _____

Level of Pain:

(none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Frequency (circle which applies):

Constant Frequent Occasional Intermittent

Onset:

Sudden Gradual

When did this start?

Days : _____ Weeks: _____ Years: _____

Progression:

Getting Better ____ Staying the Same ____ Getting Worse ____

Previous Episodes:

Yes _____ No _____

What Exacerbates the Condition: _____

What Alleviates the Condition: _____

Quality of Pain (circle all that apply):

DULL ACHY STIFF SHARP TINGLING NUMB STABBING THROBBING

Is It Worse a Certain Time of Day:

Morning Noon Evening While Sleeping No Specific Time

Have You Seen Anyone for Your Chief Complaint (s), if so, Who/Where: _____

_____

Have you seen a chiropractor Before: Yes____ No ____

PREVIOUS TRAUMAS/HOSPITIALIZATIONS/SURGERIES:

_____

_____

CURRENT MEDICATIONS: _____

_____

_____

HOBBIES: _____ _____

Name: _____

Date: _____

Please **CIRCLE** if you **CURRENTLY (C)** Have or Have Had in the **PAST ADULT LIFE (CHRONICALLY) (P)** Any of the Following Issues:

GENERAL			**DIABETES**			**GYNECOLOGIC**		
Fatigue	C	P	Low Blood Sugar	C	P	Irregular Menses	C	P
Decreased Appetite	C	P	High Blood Sugar	C	P	Abn. Vaginal Discharge	C	P
Fevers	C	P	Digestion Problems	C	P	Pelvic Pain	C	P
Weight Loss	C	P	Lipids	C	P	Pain with Intercourse	C	P
Weight Gain	C	P	Loss of Consciousness	C	P	Painful Menses	C	P
Insomnia	C	P	Sores on Feet	C	P	STD's	C	P
Smoke	C	P	Tingling/Numbness in Feet	C	P	Pregnant	C	P
Drink Alcohol	C	P						
History of Cancer	C	P						
			GASTROINTESTINAL	C	P	**MUSCULOSKELETAL**		
EYES, EARS, NOSE & THRC			Abdominal Pain	C	P	Joint Pain	C	P
Visual Changes	C	P	Constipation	C	P	Muscle Pain	C	P
Hearing Loss	C	P	Bloody Stool	C	P	Leg Swelling	C	P
Sore Throat	C	P	Diarrhea	C	P			
Nasal Congestion	C	P	Heartburn	C	P			
Runny Nose	C	P	Nausea/Vomiting	C	P	**NEUROLOGIC**		
Ear Pain	C	P				Headaches	C	P
						Dizziness	C	P
NECK			**GENITOURINARY**	C	P	Difficulty Walking	C	P
Swollen Glands	C	P	Change in Bowel Habits	C	P	Numbness or Tingling	C	P
			Painful Urination	C	P	Seizures	C	P
RESPIRATORY			Bloody Urine	C	P			
Shortness of Breath	C	P	Increased Urination	C	P			
Cough	C	P	Leaking Urine	C	P	**PSYCHIATRIC**		
Wheezing	C	P	Erectile Dysfunction	C	P	Anxiety	C	P
						Irritability	C	P
CARDIOVASCULAR			**SKIN**			Sexual Problems	C	P
Chest Pain	C	P	Rashes	C	P	Suicidal Ideation	C	P
Palpitations	C	P	Itching	C	P	Depression	C	P
High Blood Pressure	C	P	Mole Changing	C	P			
Stroke	C	P						

As a patient, I have the right to be informed about my health condition(s) and recommended treatments. Dr. Lee will discuss the potential benefits, risks and hazards involved. After signing this consent form, I understand I can withdraw consent at any time.

The information I have provided is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs.

I give my written consent for evaluation and treatment. I intend this as a consent form to cover my entire course of treatments including any future conditions for which I seek treatment.

_____

Signature

ACTIVITIES OF DAILY LIVING CHECKLIST

Select all of the following activities that you have difficulty doing:

- ☐ Bathing
- ☐ Bending over
- ☐ Bowling
- ☐ Brushing teeth
- ☐ Carrying
- ☐ Cleaning
- ☐ Climbing Stairs
- ☐ Clipping finger/ toes nails
- ☐ Cooking
- ☐ Coughing
- ☐ Crawling
- ☐ Crossing legs
- ☐ Cycling
- ☐ Dancing
- ☐ Doing the dishes
- ☐ Dressing
- ☐ Driving
- ☐ Eating
- ☐ Exercising
- ☐ Gardening/yard work
- ☐ Hiking
- ☐ Housework/chores
- ☐ Kneeling
- ☐ Knitting
- ☐ Laundry
- ☐ Lifting heavy objects
- ☐ Looking left or right
- ☐ Lying
- ☐ Picking things up from the floor
- ☐ Playing an instrument
- ☐ Playing sports
- ☐ Playing with grandkids
- ☐ Pulling
- ☐ Pushing
- ☐ Putting on clothes
- ☐ Putting on shoes/socks
- ☐ Reaching
- ☐ Reading
- ☐ Resting
- ☐ Riding a bike
- ☐ Running
- ☐ Sexual intercourse
- ☐ Shaving
- ☐ Shopping
- ☐ Sitting
- ☐ Sleeping
- ☐ Sliding
- ☐ Sneezing
- ☐ Squatting
- ☐ Standing
- ☐ Stretching
- ☐ Swinging
- ☐ Taking medications
- ☐ Taking the trash out
- ☐ Tying your shoes
- ☐ Using the bathroom
- ☐ Walking
- ☐ Working out/gym
- ☐ Writing
- ☐ Yoga

Other:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

301-924-6444

Life Chiropractic of Olney

Dr. April Lee, Chiropractor
18120 Hillcrest Avenue
Olney, Maryland 20832

Orthopedics
Biomechanics
Sports Injuries
Low Back
Syndrome
Personal Injury

Cancellation / No Show for Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows", and late cancellations inconvience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment
In order to be respectful of the medical needs of other patients, please be courteous and call Life Chiropractic of Olney promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call **at least 24 hours in advance**.

No Show Policy
A "no-show" is someone who misses an appointment without cancelling within the 24 hour advanced notice or does not reschedule in that same week. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show".

- ✓ Missed appointment or same day cancellation: $25.00 fee will be due on your following visit
- ✓ This is NOT covered by your insurance company
- ✓ If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length

I have read and understand the Cancellation / No Show for Appointment Policy and agree to be bound by its terms.

_____ _____
Printed Name Relationship to Patient

_____ _____
Signature (Self / Guardian) Date

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

_____

Patient's Signature Date

_____

Guardian's Signature Date

X-RAY QUESTIONNAIRE: **FOR WOMEN ONLY**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

- ☐ There is a possibility that I may be pregnant at this time.
- ☐ Yes. I am definitely pregnant
- ☐ No. I am definitely not pregnant at this time
- ☐ I request that x-ray films not be taken because _____

_____

_____

Date of last menstrual period: _____

_____

Patient's Signature Date

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. You have the right to obtain a paper copy of this notice upon request.

PATIENT HEALTH INFORMATION: Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information.

HOW WE USE YOUR PATIENT HEALTH INFORMATION: We use health information about you for treatment, to obtain payment, and for health care operations including administrative purposes and evaluation of the quality of the care that you receive. Under some circumstances, we may be required to use or disclose the information without your permission.

EXAMPLE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS: Treatment: We will use and disclose your health information to provide you with medical treatment and services. We may disclose the information to other health care providers who are participating in your treatment and family members who are helping with your care. Payment: We may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment and to assess the care and outcomes of your case and others like it.

SPECIAL USES: We may use your information to contact you with appointment reminders. We may do this by way of an answering machine or one who answers your telephone.

OTHER DISCLOSURES AND USES: We may use and disclose identifiable health information about you for other reasons, even without your permission. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes: Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect or similar injuries and events. Research: We may use or disclose information for approved medical/chiropractic research. Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs and similar activities. Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order. Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials. Death: We may report information regarding deaths to coroners, medical examiners, funeral directors and organ donation programs. Serious Threat to Health or Safety: We may sue and disclose information when necessary to prevent a serious threat to your health and safety or the or the health and safety of the public or another person. Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes. Workers Compensation: we may release information about you for worker's compensation or similar programs providing benefits for work related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

INDIVIDUAL RIGHTS:
You have the following rights with regard to your health information. Please contact the contact person listed below to obtain the appropriate form for exercising these rights. Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but, if we agree, we must abide by those restrictions. Confidential Communications: You may ask us to communicate with you confidentially by, for example by sending notices to a special address or not using postcards or phone/voice mail to remind you of appointments and results. Inspect and obtain copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies. Amend Information: If you believe hat information in your record is incorrect, or, if important information is missing, you have the right to request that we correct the existing information or add the missing information. Accounting of Disclosure: You may request a list of institutes where we have disclosed health information about you for reasons other than treatment, payment, or healthcare operations.

COMPLAINTS: If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filling a complaint.

CONTACT PERSON: If you have any questions, requests, or complaints, please contact: Life Chiropractic of Olney.

I, _____ hereby acknowledge receipt on the Notice of Privacy Practice given to me.

(Signed): _____

Date: _____

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness seeking acknowledgement: _____ Date: _____

PATIENT FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM

Thank you for choosing Life Chiropractic of Olney for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge you understand of our patient financial policies.

Patient Financial Responsivities

- The patient (or patient's guardian, if minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patient s are responsible for payment of copays, coinsurance, deductible les and all other procedures or treatment not covered by their insurance plan.
- Copays Coinsurance, deductibles and non-covered items are due at the time of service.
- If your insurance requires a referral from your PCP it is the patient responsibility to obtain it. If we do not have one and you claim is denied from your insurance carrier you as the patient will be responsible for the full balance.
- If patient is going through a personal injury case and your personal Auto Insurance or Attorney don't pay you as the patient will be responsible for the remaining balance.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - **Charge for returned checks - $30.00**

By my signature below, I hereby authorize assignment of financial benefits directly to Life Chiropractic of Olney and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Acknowledgement and Authorization

- We respect patient confidentiality and only release persona health information about you in accordance with the State and federal law. The attached notice describes our related to and use of the records of your care and how you may get access to the information. Please review this policy carefully.

By my signature below, I acknowledge that I have received and read the privacy notice provided by Life Chiropractic of Olney. I hereby authorize Life Chiropractic of Olney and the physicians, staff, and hospitals associated with Life Chiropractic of Olney to release medical and other information acquired during my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____

Witness: _____