We reserve the right to charge $50 for appointments cancelled or broken without 24 hours advance notice.

Delfine and Hiles Chiropractic Center
1041 Morrell Avenue
Connellsville, PA 15425
724-628-6699

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____ Today's Date: ___/___/___

Social Security Number _____ Birth Date: ___/___/___ Age: ____ Gender: F M

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ___/___/___ Phone: (____) _____

Mother: _____ Date of Birth: ___/___/___ Phone: (____) _____

Guardian: _____ Date of Birth: ___/___/___ Phone: (____) _____

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single How many children? _____

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (____) _____

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street _____

City _____ State _____ Zip _____

Phone (____) _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (____) _____

Spouse is a student at _____ ☐ FULL-TIME ☐ PART-TIME

Who should we contact in the event of an emergency? _____ Phone (____) _____

Address of contact person _____

How did you learn about us? _____

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO Please check ALL that apply.

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO

Did it result from a *work-related* accident or cause? ☐ YES ☐ NO (briefly describe): _____

_____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

_____

Approximately, when did your injury or condition occur? ___/___/____

Describe your condition, symptoms, or the purpose of this appointment: _____

_____

Have you ever had the same or similar condition? ☐ YES ☐ NO If yes, when and describe: _____

_____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/___

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/___

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/___

Date of last physical examination? _____

What surgery have you had? _____ When? _____

Serious illnesses or conditions? _____ When? _____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: _____

What medications or drugs are you taking? _____

Have you ever suffered from:

☐ Dizziness	☐ Arthritis	☐ Digestive Disorders
☐ Backaches	☐ Headaches	☐ Nervousness
☐ Heart Trouble	☐ Numbness	☐ Sinus Trouble
☐ Diabetes	☐ Asthma	☐ Anemia
☐ Hernia	☐ Neuritis	☐ Cancer

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Do you have health insurance? ☐ YES ☐ NO ☐ Not Sure Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/___ Does the policy holder have the insurance through his/her employer? ☐ YES ☐ NO If yes, who is the employer? _____

****

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 patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of 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 owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. 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 which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/___

Rev. 11-1-08

Delfine and Hiles Chiropractic Center
1041 Morrell Ave.
Connellsville, PA 15425

Patient Questionnaire – Non-Accident

Patient Name: _____ Today's Date: ___/___/___

Date of Exam: ___/___/___ Provider: _____ New Patient ☐ Yes ☐ No

General Information Related to the Condition:

Approximately when did the conditions or symptoms begin to occur? ___/___/___

☐ No particular condition or symptoms -- Just seeking general good health

Describe the conditions, symptoms or purpose of the appointment: _____

_____

_____

_____

Additional Information Related to the Condition:

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? ☐ Yes ☐ No

When? ___/___/___

Describe: _____

_____

_____

_____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Please check any of the following symptoms you are now experiencing:

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea	☐ Head seems too heavy	☐ Neck Pain
☐ Loss of Memory	☐ Clumsiness	☐ Feet Cold	☐ Neck Stiff	☐ Tingling in arms/hands	☐ Ears Ring
☐ Hands Cold	☐ Sleeping Problems	☐ Tingling in legs/feet	☐ Face Flushed	☐ Nausea	☐ Back Pain
☐ Numbness in arms/hands	☐ Buzzing in Ears	☐ Constipation	☐ Nervousness	☐ Numbness in legs/feet	☐ Loss of Balance
☐ Cold Sweats	☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever	☐ Fatigue
☐ Irritability	☐ Loss of Smell	☐ Chest pain/rib pain	☐ Pain in arms/hands	☐ Pain in legs/feet	☐ Jaw pain
☐ Loss of strength - arms	☐ Burning muscle pain	☐ Loss of strength - legs	☐ Difficulty swallowing	☐ Sharp/shooting pain	

Other _____

Have you experienced changes to:

☐ Eyes (sight) ☐ Ears (hearing) ☐ Nose (smell) ☐ Mouth (taste) ☐ Bladder

☐ Bowels ☐ Sleep ☐ Emotion ☐ Appetite

Please Explain: _____

Have you missed work or school due to your injuries? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Number of packs: _____

Do you drink alcohol? ☐ Yes ☐ No Number of Drinks _____

Notes: _____

_____

_____

_____

Medical History:

Have you ever been in our office before? ☐ Yes ☐ No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ ___/___/___

2) _____ ___/___/___

3) _____ ___/___/___

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

Do you now or have you ever had:

☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Stroke ☐ High Blood Pressure ☐ Thyroid Problems

☐ Tuberculosis ☐ Prostate Disorder ☐ Kidney Problems ☐ Asthma ☐ Ulcer ☐ Seizure Disorder

Other: _____

Delfine and Hiles Chiropractic Center

1041 Morrell Ave

Connellsville, PA 15425

Tel: 724-628-6699 Fax: 724-628-3830

Informed Consent Document

PATIENT NAME:_____

To the patient : Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment. The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experience when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

-Spinal manipulative therapy	-Palpation	-Vital signs	-range of motion testing
-Ultrasound	-Electrical Simulation		- Muscle strength testing
-Radiographic studies	-Orthopedic testing		-Postural analysis
-Hot cold therapy	-basic neurological testing		-Office visit/Exam
-Massage	-Trigger point		-Myofascial release

The material risks inherent in chiropractic adjustment. As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to : fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care, however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options. Other treatment options for your condition may include:

- Self-administered, over –the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read (or have had read to me) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Delfine and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ Dated:_____

_____ _____

Patient's Name Doctor's Name

_____ _____

Signature Signature

_____**Signature of Parent or Guardian (If a minor)**

Delfine & Hiles Chiropractic Center
1041 Morrell Avenue
Connellsville, Pa 15425 (724) 628-6699

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 care 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. 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 your privacy.

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 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.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and 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.

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

We reserve the right to charge $50 for appointments cancelled or broken without 24 hours advance notice.

Hippa Privacy Act

When calling your home for Messages:

1. Leave a Message on Machine _____
2. Leave NO Message on Machine _____
3. You Can Leave a Message with a Family Member _____
4. Do Not leave a message with no one other than SELF ___

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

AUTHORIZATION AND ASSIGNMENT

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

You are hereby 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.

1. 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.

2. 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 hereby 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 you 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 made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly or from me. I understand that whatever amounts you do not collect from insurance company proceeds, whether it be all or part of what is due, I personally owe and agree to pay you.

3. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of _____.

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

5. This Authorization for Assignment will be in continual effect 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 _____