Case History

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
H. Phone (____)_____ W. Phone _____ Date of Birth _____ (Age _____)
Email _____ Social Security # _____
Referred by _____
Occupation _____ Employer _____
Marital Status S M D W Spouses Name _____
Spouses Occupation _____ Number of Children and Ages _____
Have you ever received Chiropractic Care? □ Yes □ No

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Loss of Wellness

Let's begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

Yes	No		Patient Comments if answer is Yes	Chiropractor's comments
		1. When you were born:		
□	□	Was the delivery long?		
□	□	Was the delivery difficult?		
□	□	Were forceps used?		
□	□	Were you breech?		
□	□	Was it a home birth?		
□	□	Was it a hospital birth?		
□	□	Was your mother given drugs?		
□	□	Was labor induced?		
		2. Growth and Development		
□	□	Were you taught how to care for your spine?		
□	□	Did you fall out of bed?		
□	□	Were you a headbanger or rocker?		
□	□	Were you breast fed?		
□	□	Childhood Sickness?		
□	□	Accidents?		
□	□	Surgery?		
□	□	Drugs?		
□	□	Did you fall while learning to walk?		
□	□	Were you picked on by siblings?		
□	□	Child Abuse		
□	□	Spanking (how?)		
□	□	Pulling ear/chin		
□	□	Other		
□	□	Chair pulled out when sat down?		
□	□	Did you fall down stairs		

Yes	No	3. Current Health Habits		
□	□	Did/do you smoke?		
□	□	Did/do you drink any alcohol?		
□	□	Diet (Do you eat health foods?)		
□	□	Have you been in accidents?		
□	□	Have you had surgery and organs Removed/replaced?		
□	□	Drugs? (Prescriptive or non-prescriptive)		
□	□	Teeth problems?		
□	□	Eye problems?		
□	□	Hearing problems?		
□	□	Exercise regularly?		
□	□	Sleeping habits (nightmares?)		
□	□	Did/do you have occupational stress?		
□	□	Physical stress?		
□	□	Mental stress?		
□	□	Hobbies/Sports injuries?		
□	□	Sleeping posture □ side □ stomach □ back		

Symptoms and Ill Health (Present State of Ill Health)

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Major Complaint _____

Pain or Problem started on _____

Pains are: □ Sharp □ Dull □ Constant □ Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work?_____ Sleep?_____ Routine?_____ Other?_____

Is condition getting progressively worse? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Other symptoms:

□ Headaches	□ Pins & Needles in Legs	□ Fainting
□ Neck Pain	□ Pins & Needles in Arms	□ Loss of Smell
□ Sleeping Problems	□ Numbness in Fingers	□ Loss of Taste
□ Back Pain	□ Numbness in Toes	□ Diarrhea
□ Nervousness	□ Shortness of Breath	□ Feet Cold
□ Tension	□ Fatigue	□ Hands Cold
□ Irritability	□ Depression	□ Stomach Upset
□ Chest Pains	□ Lights Bother Eyes	□ Constipation
□ Dizziness	□ Loss of Memory	□ Cold Sweats
□ Face Flushed	□ Ears Ring	□ Loss of Balance
□ Neck Stiff	□ Fever	□ Buzzing in Ears

Have you been under drug and medical care? _____

What medications are you taking? _____

How Long? _____ Have you had surgery? _____ What? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	□	□	□	□	□
Mother's side	□	□	□	□	□

About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins the **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

afc Wellness
Anderson Family Chiropractic
and Naturopathic Care

751 Michigan Ave, PO Box 254, Waterville OH 43566 • 419-878-8312

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Anderson Family Chiropractic LLC "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Anderson Family Chiropractic LLC Notice of Privacy Practices prior to signing this document. Anderson Family Chiropractic LLC Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Anderson Family Chiropractic LLC. The Notice of Privacy Practices for Anderson Family Chiropractic LLC is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Anderson Family Chiropractic LLC duties with respect to my protected health information.

Anderson Family Chiropractic LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

The following individual(s) may have access to any and all information involving the care I receive from Anderson Family Chiropractic:

Name: _____

Relation: _____ Phone: _____

Name: _____

Relation: _____ Phone: _____

Witness Signature:

By:_____ © _____

 Date

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care 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 attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of force 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 it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal examination, we encounter a non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

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 and therefore accept chiropractic care on this basis.

Patient Signature _____ Date _____

Witness Signature By:_____© Date _____

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PAYMENT POLICY

Payment is due at the time services are rendered. After 60 days of non-payment, an 8% interest fee will be added to your account to be compounded monthly. There is a $25.00 returned check fee, which is to be paid no more than three (3) business days after notification from AFC.

A twenty-four (24) hour advance notice is required for all canceled appointments that consist of Exams, X-rays, and/or Report of Findings. A four (4) hour notice is required for all canceled appointments for Adjustments. If advance notice is not provided, you may be subject to a fee. Missed appointments will result in a $20.00 rescheduling fee.

INSURANCE ASSIGNMENT PROGRAM

It is our desire to assist our patients whenever possible. The following insurance assignment program allows you, our patient to receive the care you need without undue financial strain.

1. If you have any form of an insurance reimbursement account, such as, but not limited to, a Health Savings Account, it is your responsibility to retrieve your money from that account. We will still expect payment when services are rendered. You are also entitled to one free copy of medical records.
2. Waiting for insurance payment is a courtesy provided by this clinic. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during your corrective care period. Direct assignment will be discontinued when you have finished corrective care and supportive health care program is recommended. We will notify you of the change.
3. All deductible amounts must be paid by you in advance of the first billing. Also, you must stay current with your percentage of responsibility. This must be paid at least weekly. Prepayments may also be made.
4. The insurance carriers are billed on specific 7-10 day cycles. It is your responsibility to supply this office with necessary forms to complete billing if needed. Social Security numbers are required by this facility for billing and financial services and by refusing to provide this information you acknowledge that you may be refused service.
5. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within three days of receipt and endorse it over to the clinic. Failure to do this may result in collection action. Provided, however, that if your delinquent account is turned over to a 3rd party collection agency, then you agree to pay all reasonable collection costs including reasonable attorney fees and court costs.
6. If you discontinue your care for any reason other than discharge by the doctor, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company, at the time you discontinue care.
7. This clinic does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay all the charges and pursue reimbursement from the insurance company on his/her own. The insurance company has 30 days from billing date to make this decision. Patient payment is expected on any fees over 30 days old.

I have read the above provisions and wish to participate in the cash/insurance assignment program. I hereby agree to abide by the provisions specified above.

Patient Signature _____ Date _____

Witness Signature By:_____ © Date _____

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Insurance Information

Patient: _____

Policy Holder: _____

Social Security #: _____

Date of Birth: _____

Employer: _____

Claim Group: _____

ID#: _____

I hereby instruct and direct _____ Insurance Company to pay

Anderson Family Chiropractic, LLC PO Box 254 Waterville, OH 43566

For any and all services performed in and/or provided by their office.

Patient authorizes the Doctor to deposit checks received on Patient's account from the above insurance provider when made out to the Patient.

In case of emergency, please contact:

1st Contact _____

Address _____

_____

Phone _____

2nd Contact _____

Address _____

_____

Phone _____

Patient Signature:

_____ _____

Date

Witness Signature:

By: _____ ©

_____

Date

Notice of Our Privacy Practices

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY.

If you have questions about this notice, please contact:

Anderson Family Chiropractic, LLC, Jay Anderson, D.C., 751 Michigan Avenue, Waterville, OH 43566, (419) 878-8312

YOUR RIGHTS

You have a right to:

- Request a copy of your paper or electronic medical record
  - You can ask to see or receive an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Correct your paper or electronic medical record
  - You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communication
  - You can ask us to contact you in a specific way or to send mail to a different address. We will say "yes" to all reasonable requests.
- Ask us to limit the information we share
  - You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
  - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Request a list of those with whom we've shared your information
  - You can ask for a list of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
  - We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Request a copy of this privacy notice
  - You can ask for a paper copy of this notice at any time, and we will provide you with a paper copy promptly.
- Choose someone to act for you
  - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
  - We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you believe your privacy rights have been violated
  - You can complain if you feel we have violated your rights by contacting us using the information on page 1.
  - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
  - We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- In these cases, you have both the right and choice to tell us to:
  - Share information with your family, close friends, or others involved in your care
  - Share information in a disaster relief situation
  - Include your information in a hospital directory

***If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

- In these cases we *never* share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes
- In the case of fundraising:
  - We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Treat you: We can use your health information and share it with other professionals who are treating you.
- Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information? We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- Help with public health and safety issues
  - We can share health information about you for certain situations such as: Preventing disease; Helping with product recalls; Reporting adverse reactions to medications; Reporting suspected abuse, neglect or domestic violence; Preventing or reducing a serious threat to anyone's health or safety.
- Do research
  - We can use or share your information for health research.
- Comply with the law
  - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests
  - We can share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director
  - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests
  - We can use or share health information about you: For workers' compensations claims; For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized by law; For special government functions such as military, national security and presidential protective services.
- Respond to lawsuits and legal actions
  - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Last Updated 3/10/2021