MILLER CHIROPRACTIC – DR. KEVIN G. MILLER

TODAY'S DATE_____

NEW PATIENT INFORMATION - UPDATED PATIENT INFORMATION

NEW PATIENT_____ UPDATED INFORMATION_____

NAME_____DOB:_____/_____/_____PATIENT#_____

ADDRESS_____SS#_____

CITY, STATE, ZIP_____

HOME PHONE_____CELL_____WORKPHONE_____

EMAIL_____Yes No GENDER: Male Female

PLEASE CIRCLE: Single Married Divorced Separated Widowed Student

SPOUSE'S NAME_____OCCUPATION_____

EMPLOYER_____EMPLOYER ADDRESS_____

PRIMARY CARE DOCTOR_____PHONE#_____

REFERRED BY_____

PLEASE CIRCLE IF APPLICABLE: Work Related Injury MVA PI OTHER

INSURANCE INFORMATION: We do our best to verify your chiropractic benefits with your insurance provider, however we do not always receive accurate or up to date information. In some instances, an insurance provider may deny payment despite our best efforts to demonstrate the necessity for treatment. Please be advised that you are financially responsible for any treatments received here at Miller Chiropractic. Also, we are unable to keep track of the number of chiropractic visits you receive, as you may have seen a Chiropractor elsewhere. If requested, we are happy to provide the number of visits you have had here, but we are unable to track your visits. We highly encourage you to contact your insurance provider for the most up to date chiropractic benefits you are entitled to. Thank you for your cooperation.

INSURANCE_____SUBSCRIBER NAME_____

GROUP#_____POLICY#_____

SECONDARY INS_____SUBSCRIBER NAME_____

GROUP#_____POLICY#_____

PLEASE CIRCLE IF APPLICABLE: Work Related Injury MVA PI OTHER

ATTORNEY INFO/PH#_____

INS. INFO./ADJUSTER/PH#_____

POLICY/CLAIM#_____

24 HOUR CANCELLATION NOTICE IS REQUIRED TO AVOID A $25 MISSED APPOINTMENT FEE

Signature_____Date_____

Miller Chiropractic, Inc.
Kevin G. Miller, D.C.

"Pain Relief Today . . . . . Health For A Life Time"

New Patient Symptom Assessment Form

Patient Name: _____ **DOB :** _____

DESCRIBE YOUR CURRENT PROBLEM:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain

☐Other _____

IS THIS? Work Related Auto Related Sports Chronic N/A

Date Problem Began _____

Pain Level When Problem Started:

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How Problem Began _____

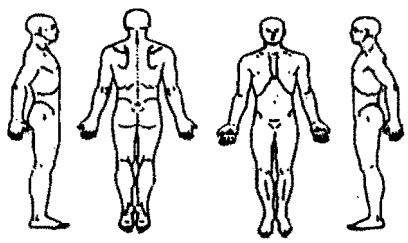
_____

Current Complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

Please mark areas of pain or other areas on figure below:



Indicate Pain Type:

Sharp
Stab
Burn
Ache
Stiffness
Pins/Needles
Numbness

How often are your symptoms present?

(Occasional) ☐0-25% ☐26-50% ☐51-75% ☐ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (work, social, household):

0 1 2 3 4 5 6 7 8 9 10

No Interference Unable to Carry on Any Activities

In general would you say your overall health right now is:

☐Excellent ☐ Very Good ☐Good ☐ Fair ☐Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐Yes

Date (s) taken _____ What areas were taken? _____

What aggravates your condition? BENDING LIFTING PUSHING PULLING SITTING STANDING

OTHER _____

Is this condition interfering with: WORK SLEEP SPORTS OTHER (Please explain)

_____

What provides relief for your condition? HEAT COLD MEDICATION REST OTHER _____

Has this condition ever happened before? _____

Any physical complaints prior to this incident? _____

Have you lost time from work as a result of this condition? _____

Have you received care from another provider for this condition? YES NO Explain _____

Are you under the care of any other provider for any other condition? YES NO Explain _____

_____

Please check all of the following that apply to you:

☐Alcohol/Drug Dependence
☐Recent Fever
☐Diabetes
☐High Blood Pressure
☐Stroke (Date) _____
☐Corticosteroid Use (Cortisone, Prednisone, etc.)
☐Taking Birth Control Pills
☐Dizziness/Fainting
☐Numbness in Groin/Buttocks
☐Cancer/Tumor (Explain)
_____
☐Osteoporosis
☐Epilepsy/Seizures

☐Prostate Problems
☐Menstrual Problems
☐Urinary Problems
☐Currently Pregnant
Weeks _____
☐Abnormal Weight ☐Gain ☐Loss
☐Marked Morning Pain/Stiffness
☐Pain Unrelieved by Position or Rest
☐Pain at Night
☐Visual Disturbances
☐Surgeries
_____
_____
_____

☐Tobacco Use -- Type
_____
Frequency ____/Day

☐Headaches
☐Night Sweats
☐Difficulty Digesting/Eating
☐Difficulty Using Bathroom
☐Pins/Needles
☐Chills
☐Weakness
☐Pains in Arms/Legs
☐Other Health Problems (Explain) _____

List any past serious accidents or injuries with dates : ☐ None

_____

_____

Please list all medications: _____

_____

Please list any nutritional supplements/vitamins that you take: _____

_____

Would you be interested in nutritional supplement counseling, or the Nu-Lean detox program? ☐ Yes ☐ No

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke
☐ Rheumatoid Arthritis ☐ Thyroid Disease ☐ Kidney Disease ☐ Muscle/Bone/Nerve Disease
☐ Other_____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature _____ Date _____

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 your sign this consent form (§ 164.520). 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 our privacy notices.

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.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

X _____ _____

Printed Name Authorized Provider Representative

X _____ _____

Signature Date

X _____

Date

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.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. 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. In addition, 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.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

X _____ X _____

Patient name printed | Date

X _____ _____

Patient Signature | Authorized Provider Representative

_____ _____

Personal Representative Printed | Personal Representative Signature

_____

Description of personal representative's authority to act for the patient.

MILLER CHIROPRACTIC INC.

KEVIN G. MILLER, D.C.

COMMERCIAL INSURANCE/PRIVATE INSURANCE DISCLOSURE

****PLEASE READ CAREFULLY****

I HEREBY AUTHORIZE MILLER CHIROPRACTIC, INC. TO RECEIVE ANY INFORMATION WHICH MAY HAVE BEEN ACQUIRED BY EXAMINATION OR OTHER MEANS, OF MY PHYSICAL OR MENTAL CONDITION; AND HEREBY RELEASE HIM OF ANY CONSEQUENCE THEREOF.

I HEREBY AUTHORIZE RELEASE AND/OR TRANSFER OF ALL RECORDS AND ANY INFORMATION NECESSARY TO FILE A CLAIM WITH MY INSURANCE COMPANY, FOR THE PURPOSE OF COORDINATING THE PAYMENT OF CLAIMS WITH MY HEALTH INSURER, AND TO ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO DR. MILLER. (IF APPLICABLE, THESE SAME CONDITIONS ALSO AUTHORIZE MILLER CHIROPRACTIC, INC. TO RELEASE AND/OR TRANSFER ALL RECORDS AND ANY INFORMATION NECESSARY AS REQUESTED BY MY ATTORNEY, AS NAMED BELOW)

_____

Name and Address of Patient's Attorney

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL BALANCES NOT COVERED BY MY INSURANCE COMPANY AND/OR 3RD PARTY INVOLVED.

I UNDERSTAND THAT THERE WILL BE A $25.00 CHARGE FOR ALL APPOINTMENTS THAT ARE CANCELLED OR MISSED WITHOUT A 24-HOUR NOTICE.

I UNDERSTAND THAT THERE WILL BE A $ 30.00 FEE FOR ANY RETURNED CHECKS.

I UNDERSTAND THAT ALL BILLS SENT TO ME BY MILLER CHIROPRACTIC, INC. ARE SUBJECT TO A $10.00 BILLING CHARGE.

I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ALL LEGAL FEES AND/OR COLLECTION FEES INCURRED BY MILLER CHIROPRACTIC, INC., IN THE EVENT THAT SUCH ACTION IS TAKEN TO ENSURE FULL AND COMPLETE PAYMENT OF ANY AND ALL BALANCES OWED TO MILLER CHIROPRACTIC, INC. BY ME.

** PLEASE NOTE THAT IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN ALL REFERRALS NECESSARY FOR CHIROPRACTIC CARE. WITHOUT A REQUIRED REFERRAL, THE PATIENT IS RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME OF VISIT **

X SIGNATURE:_____ DATE:_____

A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL.

Informed Consent Form

Kevin G. Miller, D.C.
863 Broadway
East Providence, RI 02914

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic, Dr. Kevin G. Miller and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above.

I have had an opportunity to discuss with Dr. Kevin G. Miller and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date_____

Witness Signature_____ Date_____