CPC
CROWN PLAZA
CHIROPRACTIC, LLC
at Regent Park

Crown Plaza Chiropractic, LLC
3160 Hwy. 21 North, Suite 106
Fort Mill, SC 29715
803-548-9091

Patient Information Form

Print Form PLEASE ENTER INFORMATION IN ALL CAPS ,

Patient Demographics:

Chart Number Office use only

Last Name First Name MI:

Date of Birth Gender M or F Suffix:

Marital Status:

Address Line 1: Address Line 2:

City State: Zip Code:

Home Phone: Work Phone:

Cell Phone: Email:

Employment Information:

Employer Name: Employer Phone:

Address Line 1: Address Line 2:

City State: Zip Code:

Emergency Contact:

Contact Name: Relationship:

Address Line 1: Address Line 2:

City State: Zip Code:

Home Phone: Cell Phone:

Insurance Information:

Insurance Name:

Primary Insured

Last Name: First Name: MI:

Patient Relationship to Primary Insured DOB of Primary Insured:

Subscriber ID Group Number:

Signature: Date:

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Patient Health Information

Patient Condition:

Reason for Initial Visit:

When did problem start?

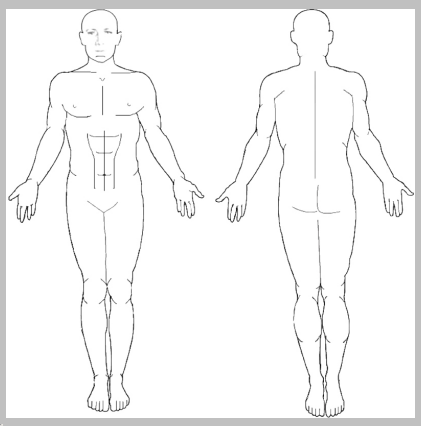
Is condition due to an accident? ☐ Auto ☐ Work ☐ Home ☐ Other

Is the pain...

☐ Sharp ☐ Burning ☐ Aching ☐ Cramping

☐ Other ☐ Numbness/ Tingling ☐ Shooting ☐ Throbing ☐ Dull

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain)



Mark areas of pain with an X

Health History::

What treatment have you already received for your condition: ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ Other:

Check the box to indicate if you have had any of the following:

☐ AIDS/HIV	☐ Epilepsy	☐ Migraine Headaches	☐ Prosthesis
☐ Alcoholism	☐ Fractures	☐ Mononucleosis	☐ Psychiatric Care
☐ Allergies	☐ Gout	☐ Multiple Sclerosis	☐ Rheumatoid Arthritis
☐ Anemia	☐ Heart Disease	☐ Osteoporosis	☐ Sexually Transmitted Disease
☐ Arthritis	☐ Hepatitis	☐ Pacemaker	☐ Stroke
☐ Asthma	☐ Hernia	☐ Paralysis	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Herniated Disc	☐ Parkinson's Disease	☐ Tuberculosis
☐ Breast Lump	☐ Herpes	☐ Pinched Nerve	☐ Tumors, Growths
☐ Cancer	☐ High Blood Pressure	☐ Pneumonia	☐ Ulcers
☐ Chicken Pox	☐ High Cholesterol	☐ Polio	☐ Vein Conditions
☐ CVA (Stroke)	☐ Kidney Disease	☐ Prostate Problem	☐ Vaginal Infections
☐ Diabetes	☐ Liver Disease	☐ Other:	

Additional Information:

EXERCISE

☐ None ☐ Moderate ☐ Daily ☐ Heavy

WORK ACTIVITY

☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

HABITS

☐ Smoking Packs/Day
☐ Alcohol Drinks/Week
☐ Coffee/ Caffeine Drinks Cups/Day
☐ High Stress Level Reason

Are you pregnant? ☐ No ☐ Yes Due Date

MEDICATIONS

ALLERGIES

VITAMINS/ HERBS/ SUPLEMENTS

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HIPPA Consent Form ,

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Crown Plaza Chiropractic to use and disclose protected health information about me to carry out treatment, payment, and healthcare operations.

With this consent, Crown Plaza Chiropractic may call, mail, and e-mail to my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others. Any mailed items should be marked personal and confidential.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health-care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at 3160 Hwy. 21 North, Suite 106, Fort Mill, SC 29715 to obtain a current copy of the Notice of Privacy Practices.

I have the right to request in writing that Crown Plaza Chiropractic restrict how it uses or discloses my protected health information to carry out treatment, payment, and healthcare operations.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Crown Plaza Chiropractic use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Crown Plaza Chiropractic may decline to provide treatment to me.

CONSENT FOR CARE
I authorize the performance of examination, x-ray (when needed), and chiropractic treatment to be performed by, or under the direction of, Dr. Williams and / or such doctors/paraprofessionals/assistants as may be selected by the doctor to perform such professional procedures, as he/she deems necessary.

Patient Signature: _____

Date: _____

COMPLETE IF PATIENT IS A MINOR CHILD.

I, as the parent or legal guardian of this patient have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive care at Crown Plaza Chiropractic.

Parent or Guardian Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this form, but was unable to do so as documented below:

Reason _____ Staff Signature _____

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Terms Of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working together 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: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The 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 its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter 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 another health care provider.

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 major interference to the expression of the body’s innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, may use other procedures to help your body hold the adjustments.

I, _____ _____ have read and fully understand the above statements.

All questions regarding the doctor’s objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

Patient Signature: _____

Date: _____

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Clinic Policies

The following is an explanation our clinic policies. We believe that a clear definition will allow us to concentrate on the most important issue: regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account, or insurance coverage.

No Charge Consultation

Crown Plaza Chiropractic will do a special "no charge" consultation, or brief conference, with anyone interested in finding out if chiropractic can help them with their individual health problem. There is no charge or obligation in connection with this appointment.

Patient Payment Policy

We feel the patient's health needs are paramount: therefore the following payment policy is an attempt to allow you, the patient, to receive that care you need and clear your balance with the least amount of difficulty.

We require full payment of the first visit charges due on the first day of service unless we bill your insurance for payment. Properly documented Worker's Compensation claims are not required to pay at this time if appropriate forms are signed.

Patients under care are required to make regular payments on all unpaid balances, except for properly documented Worker's Compensation claims. Crown Plaza Chiropractic has payment plans for those patients without insurance. Payments need to be paid semi-monthly or monthly, depending on your arrangements. We do charge $15.00 late fees for unpaid monthly payments. A $25.00 service charge will be applied for all returned checks.

Today most insurance policies do offer chiropractic care. We will be happy to bill your primary insurance claim for you and do everything we can to insure you receive proper reimbursement; however, we cannot take responsibility for what your health insurance will or will not cover. Insurance is filed as a courtesy to our patients and is the patient's responsibility to follow up on their payments and benefits. It is important to understand that health and accident insurance policies are an arrangement between an insurance carrier and you, the patient, and their insured. Of course, Crown Plaza Chiropractic, LLC will prepare any necessary reports and forms to assist you in making collection from your insurance company. Furthermore, any amount authorized to be paid directly to Crown Plaza Chiropractic, LLC will be credited to your account on receipt. You must clearly understand and agree that all services rendered to you are charged directly to you and that you are personally responsible for payment.

In order to better serve our patients, we ask that you call if you are unable to make your appointment or if you will be late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. Therefore, we have the right to charge you a fee of $35 for missed appointments without cancellation notice. Please help us help others.

Any questions about any aspect of your care of account are invited. Please feel free to ask your doctor or any available staff member. We will make every effort to answer your inquiries.

I have read the Crown Plaza Chiropractic clinic policies and will honor them:

Patient Signature: _____

Date: _____

Print Form