Moncks Corner Chiropractic
843-761-4470 phone
843-695-7932 fax
www.monckscornerchiropractic.com

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Home #:_____

Email: _____ Cell #:_____

Physical Address: _____ Mailing Address, if different:

_____ _____

_____ _____

Occupation: _____ Employer: _____

Work #: _____

Please circle the best way to contact you: Home# / Cell# / Work# / Email

Age: _____ Birthdate: _____ SS #: _____

Marital Status: (circle) married single divorced widow separated

Spouse's Name: _____ **Spouse DOB:** _____

Emergency Phone #: _____ **Emergency Contact:** _____

Relationship: _____

Primary Ins. Carrier: _____Policy #_____

Policy Holders Name: _____

Secondary Ins. Carrier: _____Policy #_____

Who is your Family Physician? _____

If you were referred by a family member or friend, please provide their name so we may thank them properly.

_____

We appreciate your cooperation in getting all the necessary information to our staff, we will be with you momentarily!

*Staff Use - Date Entered*_____ *Filed*_____ *Initial*_____

Patient Health History

1.) What concern brings you in today?_____

2.) When did you first notice this? _____

3.) Why do you think caused this? _____

4.) Have you been treated for this before? If so please explain:_____

5.) Recent MRI/xrays/surgeries:_____

6.) How would you describe the intensity/sensation? (Please check all that apply)

- ○ Dull
- ○ Burning
- ○ Tingling
- ○ Numbness
- ○ Sharp
- ○ Deep
- ○ Stabbing
- ○ Radiating
- ○ Throbbing
- ○ Aching
- ○ Cramping

Other _____

7.) How does this interfere with your life? _____

8.) Please indicate the average intensity/level of pain by marking an 'X' on the line where appropriate.

0 1 2 3 4 5 6 7 8 9 10

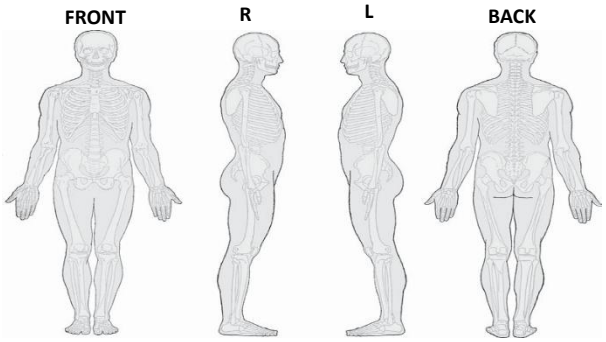
NO PAIN MILD PAIN MODERATE PAIN SEVERE PAIN

9.) How often do you experience this?

- ○ Less than 26% of the time
- ○ 26-50% of the time
- ○ 51-75% of the time
- ○ 76-100% of the time

10.) Are your concerns worse:

- ○ In the morning
- ○ At mid-day
- ○ At the end of the day
- ○ At night before bed
- ○ My experience is the same throughout the day



Please mark your area(s) of concern

X - Pain
O - Spasm
N - Numbness

11.)What aggravates it? (Please check all that apply)

○ Sitting	○ Stooping	○ Coughing	○ Looking up	○ Laying Down	○ Household chores
○ Standing	○ Lifting	○ Straining	○ Looking down	○ Driving	○ Exercise
○ Walking	○ Sleeping	○ Reaching	○ Movement	○ Typing	○ Stair Stepping
○ Bending	○ Sneezing	○ Twisting	○ Rest	○ Scooping	Other:_____

12.)What relieves it? (Please check all that apply)

○ Sitting	○ Knees Bent	○ Movement	○ Heat	○ Medicine
○ Standing	○ Support	○ Not Moving	○ Ice	○ Chiropractic Adjustments
○ Laying Down	○ Rest	○ Stretching/Exercise	○ Topical Solution	

13.) Current Medications or circle NONE: _____

(Females only): **Is there any chance you might be pregnant?** ☐Yes ☐No **First day of your last menstrual cycle?**____ /____ / ____

HISTORY – Have you experienced any of the Following Issues?

High / Low Cholesterol	☐Current ☐Past ☐Never	**Neck Pain**	☐Current ☐Past ☐Never	**Female Ovarian / Pelvic**	☐Current ☐Past ☐Never
High / Low Blood Pressure	☐Current ☐Past ☐Never	**Headaches**	☐Current ☐Past ☐Never	**Stroke**	☐Current ☐Past ☐Never
Circulation Problems	☐Current ☐Past ☐Never	**Radiating Pain**	☐Current ☐Past ☐Never	**Blood Clots**	☐Current ☐Past ☐Never
Heart Condition	☐Current ☐Past ☐Never	**Numbness**	☐Current ☐Past ☐Never	**Other Digestive Problem**	☐Current ☐Past ☐Never
Cancer	☐Current ☐Past ☐Never	**Arm Pain**	☐Current ☐Past ☐Never	**Stomach Problems**	☐Current ☐Past ☐Never
Ear Infections	☐Current ☐Past ☐Never	**Upper Back Pain**	☐Current ☐Past ☐Never	**Difficulty Sleeping**	☐Current ☐Past ☐Never
Asthma	☐Current ☐Past ☐Never	**Low Back Pain**	☐Current ☐Past ☐Never	**Fatigue**	☐Current ☐Past ☐Never
Respiratory Condition	☐Current ☐Past ☐Never	**Leg Pain**	☐Current ☐Past ☐Never	**Aids/HIV**	☐Current ☐Past ☐Never
Taste/Saliva Problems	☐Current ☐Past ☐Never	**Fractures**	☐Current ☐Past ☐Never	**Liver Disease**	☐Current ☐Past ☐Never
Smell/Nose Disorders	☐Current ☐Past ☐Never	**Arthritis**	☐Current ☐Past ☐Never	**Current Open Wounds**	☐Current ☐Past ☐Never
Allergies	☐Current ☐Past ☐Never	**Spine Surgery**	☐Current ☐Past ☐Never	**Kidney Problem**	☐Current ☐Past ☐Never
Eye Problems	☐Current ☐Past ☐Never	**Weight Loss/Gain**	☐Current ☐Past ☐Never	**Endocrine Disorder**	☐Current ☐Past ☐Never
Hearing Deficit	☐Current ☐Past ☐Never	**Diabetes**	☐Current ☐Past ☐Never		

Print Name:_____ **Signature:** _____ **Date:** _____

Assignment and Authorization

I, _____ hereby authorize and direct any insurance company and/or attorney to pay directly to you, *Dr. Nicholas McCoy,* all sums as may be due and owing to me for services rendered to me by reason of injury or other, to *Moncks Corner Chiropractic* and withhold such sums from any benefits I may be entitled to as result thereof. I hereby further give a lien to this office against any and all insurance benefits and any and all proceeds of any settlement, judgment, or verdict which may be paid to me as a result of the injuries or illnesses for which I have been treated by this office. This is an assignment of my rights and benefits to any sums payable to me by any insurance company to the extent of this office's services provided to you the patient minus any payments already provided to *Moncks Corner Chiropractic* by you the patient towards those services.

As consideration for this assignment, *Moncks Corner Chiropractic*, *Dr. Nicholas McCoy*, will forego demanding payment upon completion of each visit and will treat me without demanding payment until any insurance company has paid directly all sums due and owing or otherwise finally settled any claim I have for which the insurance company pays benefits. This does not apply to any patient responsibility, Co-pay, Co-insurance or deductible amounts unless otherwise agreed upon in writing signed by you the patient and a representative of *Moncks Corner Chiropractic*. I understand that if I am not entitled to any sums paid by any insurance company or should all sums paid by all insurance companies total less than the amount of the services rendered, I will be personally liable for any amount still owed to *Moncks Corner Chiropractic, Dr. Nicholas McCoy.* It is further understood that at any point, the monies received exceed my indebtedness, the excess balance will be returned to me by check from our office.

In the event any insurance company, obligated to make payments to me upon the charges made by the office for their services, refuses to make such payments upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my name or in the office's name and further I authorize this office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

You are 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 for services rendered to me by you or any member of your staff acting on your behalf.

Please be aware that our staff verifies your insurance information as a favor to you. Any benefit information you may have as the Insured is provided to you from your Insurer in your contract which defines any coverage you may have with your Insurance carrier. When our office verifies your coverage, this does not guarantee payment from your Insurance carrier. By signing this, you are fully aware of these conditions and understand in the default of payment, you, the patient, will be fully liable for all services rendered.

_____ _____

Date Patient Signature

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are 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 also need to request records in order to assist in your care. 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 (§ 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 with your restrictions. However, if we agree with your restrictions, that restriction is binding to 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. You will receive emails regarding your specific condition and you can elect at any time to discontinue receiving email correspondence if you chose. You agree in addition to paper statements that you may receive statements electronically for the purpose of linking you to a secure payment portal online. If any contact is made by phone and you are not at home, a message will be left on your answering service. By signing this form, you are giving us authorization to contact you via text/e-mail with these appointment reminders and pertinent patient 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 my 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 have read your policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: the doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, traction, therapeutic ultrasound, soft tissue stretching/massage, therapeutic exercise or dry hydrotherapy may also be needed.

Possible risk: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications or muscular soreness.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in a million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over the counter analgesics*. The risk of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of eases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____ _____

Printed Name, Signature Date

WITNESS:

_____ _____

Printed Name, Signature Date