BLUMENFELD FAMILY CHIROPRACTIC

DATE_____

E-MAIL ADDRESS_____

1. REQUIRED FOR YOUR CASE HISTORY FILE:

NAME_____ S.S.#_____

ADDRESS_____CITY_____STATE___ZIP_____

TELEPHONE ( ) _____ AGE_____BIRTHDATE_____

SEX_____ MARITAL STATUS (CIRCLE ONE) M S W D NO. OF CHILDREN_____

OCCUPATION_____EMPLOYER_____

WORK TELEPHONE ( )_____ SPOUSE'S NAME_____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

WHY DID YOU CHOOSE THIS OFFICE? _____

MAJOR COMPLAINTS AND SYMPTOMS_____

_____

WHEN DID YOU FIRST NOTICE THIS? _____

_____

HAS THIS EVER HAPPENED BEFORE? _____ WHEN? _____

HEIGHT_____ WEIGHT_____

FEMALE PATIENTS: ARE YOU PREGNANT? ___ YES ___ NO

OTHER COMMENTS:_____

_____

NAME OF NEAREST LIVING RELATIVE_____

ADDRESS_____ PHONE ( )_____

2. INSURANCE INFORMATION: (PLEASE CHECK ONE OR MORE OF THE FOLLOWING)

AUTO ACCIDENT ☐ WORK INJURY ☐ GROUP HEALTH INSURANCE ☐

PRIVATE HEALTH INSURANCE ☐ MEDICARE ☐ CASH PAYMENT ☐

NAME OF INSURANCE CO._____

GROUP#_____ POLICY #_____ CLAIM #_____

ADDRESS_____

INSURANCE PHONE ( )_____ AGENT_____

3. ACCIDENT-INJURY INFORMATION:

DATE_____ TIME_____AM/PM POLICE REPORT MADE?_____

DESCRIPTION OF
ACCIDENT/INJURY_____

_____

_____

DRIVER'S LICENSE STATE/NUMBER_____

PATIENT'S SIGNATURE_____

AGREEMENT OF PAYMENT FOR SERVICES RENDERED

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN THE INSURANCE CARRIER AND MYSELF. THIS OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

SIGNED_____ WITNESSED_____

DATE_____

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment form third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of privacy practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of privacy practices* prior to signing this consent. 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 any time at the address below to obtain a current of the *Notice of privacy practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name: _____

Signature: _____

Relationship to patient: _____

Date: _____

Blumenfeld Family Chiropractic

Consent to Chiropractic Services

I, _____, authorize the performance upon myself any of the following procedures as deemed clinically necessary:

-Physical Examination
-Regional Examination
-Chiropractic Adjustments
-Physical Therapeutic Modalities
-Blood Work
-Urine Analysis
-Other Laboratory Services
-Radiographic Examination
-Advanced Imaging

I understand there are charges for these services and specific charges will be explained to me upon request.

These tests are to be performed by Dr. Joel C Sellmeyer.

I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that the above named doctor may consider necessary or advisable in the course of my health care. I understand there are fees for these services and I will be charged accordingly. Specific charges will be explained to me upon request.

The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to me by the above mentioned doctor.

Date: _____ Signed: _____

Witness: _____ Relationship: _____

<u>FEMALE PATIENTS ONLY:</u> This is to certify that to the best of my knowledge I am NOT pregnant and that Dr. Sellmeyer has permission to take X-rays.
***If you even suspect that you might be pregnant, please inform the doctor. ***

Date of Last Menstrual Period: _____Signed:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPAA"). 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 HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.
- OBTAIN PAYMENT FROM THIRD-PARTY PAYERS.
- CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.

I HAVE RECEIVED, READ AND UNDERSTAND YOUR *NOTICE OF PRIVACY PRACTICES* CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE IT *NOTICE OF PRIVACY PRACTICES* FROM TIME TO TIME AND THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME AT THE ADDRESS ABOVE THE OBTAIN A CURRENT COPY OF THE *NOTICE OF PRIVACY PRACTICES.*

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT NOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

PATIENT NAME: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

DATE:	INITIALS:	REASON:

SYMPTOMS

GENERAL	severe	mild	none
Allergy	☐	☐	☐
Chills	☐	☐	☐
Convulsions	☐	☐	☐
Dizziness	☐	☐	☐
Fainting	☐	☐	☐
Fatigue	☐	☐	☐
Fever	☐	☐	☐
Headache	☐	☐	☐
Loss of sleep	☐	☐	☐
Loss of weight	☐	☐	☐
Nervousness	☐	☐	☐
Neuralgia	☐	☐	☐
Numbness	☐	☐	☐
Sweats	☐	☐	☐
Wheezing	☐	☐	☐
Weakness in arms, legs	☐	☐	☐

MUSCLE AND JOINT			
Backache	☐	☐	☐
Faulty posture	☐	☐	☐
Foot trouble	☐	☐	☐
Hernia	☐	☐	☐
Pain between shoulders	☐	☐	☐
Painful tailbone	☐	☐	☐
Spinal curvature	☐	☐	☐
Stiff neck	☐	☐	☐
Tremors	☐	☐	☐
Swollen joints	☐	☐	☐

CARDIO-VASCULAR			
Hardening of arteries	☐	☐	☐
High blood pressure	☐	☐	☐
Low blood pressure	☐	☐	☐
Pain over heart	☐	☐	☐
Paralytic stroke	☐	☐	☐
Poor circulation	☐	☐	☐
Previous stroke	☐	☐	☐
Rapid beating heart	☐	☐	☐
Slow beating heart	☐	☐	☐
Swelling of ankles	☐	☐	☐

NAME _____

SYMPTOMS

GASTRO-INTESTINAL	severe	mild	none
Belching or gas	☐	☐	☐
Colitis	☐	☐	☐
Colon trouble	☐	☐	☐
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Difficult digestion	☐	☐	☐
Distention of abdomen	☐	☐	☐
Excessive hunger	☐	☐	☐
Gall bladder trouble	☐	☐	☐
Hemorrhoids	☐	☐	☐
Jaundice	☐	☐	☐
Liver trouble	☐	☐	☐
Nausea	☐	☐	☐
Pain over stomach	☐	☐	☐
Poor appetite	☐	☐	☐
Vomiting	☐	☐	☐
Vomiting of blood	☐	☐	☐

E.E.N.T.			
Asthma	☐	☐	☐
Crossed eyes	☐	☐	☐
Deafness	☐	☐	☐
Dental decay	☐	☐	☐
Earache	☐	☐	☐
Ear discharge	☐	☐	☐
Ear noises	☐	☐	☐
Enlarged glands	☐	☐	☐
Enlarged thyroid	☐	☐	☐
Eye pain	☐	☐	☐
Failing vision	☐	☐	☐
Frequent colds	☐	☐	☐
Hay fever	☐	☐	☐
Hoarseness	☐	☐	☐
Gum trouble	☐	☐	☐
Nasal congestion	☐	☐	☐
Nose bleeds	☐	☐	☐
Near sightedness	☐	☐	☐
Sinus infection	☐	☐	☐
Sore throat	☐	☐	☐
Tonsillitis	☐	☐	☐

SYMPTOMS

RESPIRATORY	severe	mild	none
Chest pain	☐	☐	☐
Chronic cough	☐	☐	☐
Difficult breathing	☐	☐	☐
Spitting up blood	☐	☐	☐
Spitting up phlegm	☐	☐	☐

SKIN			
Boils	☐	☐	☐
Bruises	☐	☐	☐
Dryness	☐	☐	☐
Hives or allergy	☐	☐	☐
Itching	☐	☐	☐
Sensitive skin	☐	☐	☐
Skin eruptions	☐	☐	☐
Varicose veins	☐	☐	☐

GENITO-URINARY			
Bed wetting	☐	☐	☐
Blood in urine	☐	☐	☐
Frequent urination	☐	☐	☐
Inability to control urine	☐	☐	☐
Kidney infection	☐	☐	☐
Kidney stones	☐	☐	☐
Painful urination	☐	☐	☐
Prostate trouble	☐	☐	☐

FOR WOMEN ONLY			
Premenstrual tension	☐	☐	☐
Congested breast	☐	☐	☐
Menstrual cramps	☐	☐	☐
Menstrual backache	☐	☐	☐
Excessive flow	☐	☐	☐
Hot flashes	☐	☐	☐
Irregular cycle	☐	☐	☐
Lumps in breast	☐	☐	☐
Menopausal symptoms	☐	☐	☐
Painful menstruation	☐	☐	☐
Vaginal discharge	☐	☐	☐
Are you pregnant?		Yes ☐	No ☐