Short Chiropractic BACK TO HEALTH

Brett A. Short, D.C. | Luke Short, D.C. | Destiny Cooper, D.C. | Eric Cooper, D.C.,

99 Cracker Barrel Drive Ste #200
Barboursville. WV 25504

(304)733-4616 / Fax (304)733-4818

Patient Information ***Date:*** _____

Patient Name _____ Marital Status: ○Married ○Single ○Divorce ○Widowed Age: ____ Date of Birth: _____

Address _____ City _____ State ____ Zip _____ Sex: M F Height: ____ Weight: ____

Home Phone _____ Work _____ Cell _____ SS#: _____ Email: _____

Student ○Full-time ○Part-time Name of school _____ Your Occupation: _____ Employer: _____

Your Spouse's Name: _____ Spouse Date of Birth: _____ Employer : _____ Phone: _____

Name of person to contact in case of emergency: _____ Phone: _____ Relationship: _____

Name of nearest relative not living with you: _____ Phone: _____ Relationship: _____

Who referred you to this office, so we can thank them: _____ Referring Physician: _____

Is this appointment related to an accident? ○Yes ○No ☐Auto ☐Work -Date of Injury: _____ Your Medical Doctor? _____

Have you had Chiropractic in the past? ○Yes ○No If yes, When? _____ Doctor's Name: _____ Results: _____

INSURANCE COVERAGE INFORMATION

PRIMARY INSURANCE:

Insurance Carrier _____ Phone _____ Policy Holder Name _____ Insured Date of Birth _____

Policy Number _____ Group Number _____ Insured Home # _____ Relationship ○Spouse ○Child ○Other

SECONDARY INSURANCE

Insurance Carrier _____ Phone _____ Policy Holder Name _____ Insured Date of Birth _____

Policy Number _____ Group Number _____ Insured Home # _____ Relationship ○Spouse ○Child ○Other

Auto/Personal Injury: Do you have "Med Pay" on your Auto Policy: ○Yes ○No Amount $_____

Describe Major Complaints & Symptoms: _____

_____

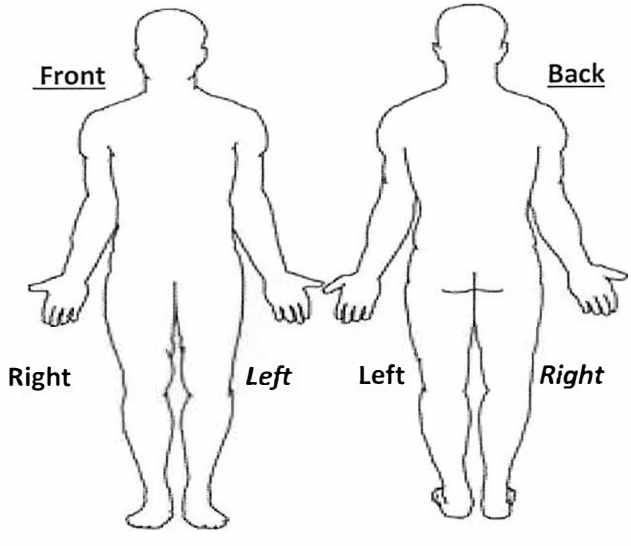
_____

Where is your pain? How Does it feel? Draw your pain using the following Key.

Key:

Stabbing ///

Burning XXX
Pins & Needles o o o
Aching ^^^
Throbbing !!!
Numbness = = =
Other *



List any doctors or therapist that you have seen for this complaint:

1. _____ Speciality: _____

2. _____ Speciality: _____

3. _____ Speciality: _____

List any operations that you've had and approximate dates:

1. _____ ***Date:*** _____ ***Dr:*** _____

2. _____ ***Date:*** _____ ***Dr:*** _____

3. _____ ***Date:*** _____ ***Dr:*** _____

Are you Allergic to any Medication? Y/N Please List: _____

_____

Are You taking any medications? Y/N Please List: _____

_____

Do you wear Orthotics(shoe inserts) Y/N If yes, what type? _____

If you have any of the following symptoms, Circle if you have them Frequent and X by the Symptom if Frequent.:

GENERAL
- ☐ Allergies
- ☐ Convulsions
- ☐ Dizziness or Fainting
- ☐ Headache
- ☐ Neuralgia
- ☐ Numbness/sensation loss

MUSCLE & JOINT
- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot Trouble
- ☐ Low Back Pain
- ☐ Neck Pain or stiffness
- ☐ Pain between shoulders
- ☐ Sciatica
- ☐ Swollen Joints
- ☐ Pain, Numbness, Cramps
- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet

GASTRO-INTESTINAL
- ☐ Colon Trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult Digestion
- ☐ Distension of Abdomen
- ☐ Gallbladder Trouble
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Pain of stomach
- ☐ Difficult Swallowing

Eyes, Ears, Nose & Throat
- ☐ Asthma
- ☐ Colds
- ☐ Hearing Loss
- ☐ Earache
- ☐ Ear Discharge
- ☐ Ear Noises
- ☐ Eye Pain
- ☐ Nasal Obstruction
- ☐ Nosebleeds
- ☐ Sinus Infection
- ☐ Blurred Vision
- ☐ Loss of Vision

CARDIO-VASCULAR
- ☐ Hardening of arteries
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pain over heart
- ☐ Poor Circulation
- ☐ Rapid Heartbeat
- ☐ Slow Heartbeat
- ☐ Swelling of Ankles
- ☐ Slurred Speech
- ☐ Weakness/Clumsiness

FOR WOMEN ONLY
- ☐ Congested Breast
- ☐ Cramps or backache
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Lumps in Breast
- ☐ Menopausal Symptoms
- ☐ Painful Menstruation
- ☐ Vaginal Discharge

Pregnant Y/N
Date of Last Period _____
Previous Miscarriages Y/N

SKIN
- ☐ Bruise
- ☐ Dryness
- ☐ Skin Eruptions (rash)
- ☐ Varicose Veins

RESPIRATORY
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Difficult Breathing
- ☐ Spitting up blood
- ☐ Spitting up Phlegm
- ☐ Wheezing

GENITO-URINARY
- ☐ Bed Wetting
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Inability to control Urine
- ☐ Kidney Infection or Stones
- ☐ Painful Irritation
- ☐ Prostate Trouble
- ☐ Pus in Urine

	None	Light	Moderate	Heavy
Alcohol	○	○	○	●
Coffee	○	○	○	●
Tobacco	○	○	○	●

	None	Light	Moderate	Heavy
Drugs	○	○	○	●
Soft Drinks	○	○	○	●
Exercise	○	○	○	●

Notes:

Relevant Medical History: (please circle the conditions you have or had previously):

Aids/HIV		Alcoholism		*Arthritis*		Asthma		Anemia	
Appendicitis		Arteriosclerosis		Back Pain/Spasms		Cancer		Chicken Pox	
Concussion		Convulsion		Diabetes		Digestion Problems		Dizziness	
Eczema		Emphysema		Epilepsy		Fibromyalgia		Foot Problems	
Goiter		Gout		Hand/Wrist Pain		Headaches		Heart Problems	
Hepatitis		High Blood Pressure		Measles		Multiple Sclerosis		Mumps	
Muscular Dystrophy		Neck Pain /Spasms		Numbness		Pacemaker		Pneumonia	
Polio		Rheumatic Fever		Scarlet Fever		Sciatica		Scoliosis	
Sinus Trouble		Stroke		Tuberculosis		Typhoid Fever		Ulcers	
Venereal Disease									

Does anyone in your family have a similar health records problems: Y/N

Who: _____ *What condition:* _____

TREATMENT OF MINOR: (Must be signed by parent or legal guardian if patient is a minor under age 18); I hereby authorize short Chiropractic Inc. and its assistants to administer chiropractic care as deemed necessary to my_____.
(Relationship)

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement. I hereby authorize and direct my medical benefits to be paid to Short Chiropractic Inc. and agree that I am financially responsible for non-covered services or items. I hereby give permission to Short Chiropractic Inc. to administer treatment and perform such general procedures as the doctor may deem necessary in the diagnosis and/or treatment for my condition.

Patient's Signature: _____ **Date:** _____

Parent or Guardian: _____ **Date:** _____

OFFICE FINANCIAL POLICY

Our Policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1 **If you do not have insurance:** all payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at anytime unless prior arrangements have been made with billing department.

2. **If you have insurance:** all deductibles and co-payments are expected at the time of service. Your co-insurance balance may not exceed $100 unless prior arrangements have been made with the billing department .

You are considered a cash patient until you bring in your insurance forms and We verify and accept your insurance coverage. Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

When your schedule of visits is once per month or longer, you may not be eligible for insurance assignment. Charges for services render will be due as they are rendered.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment. For your convenience you may retain your credit card on file with us.

Patient Signature : _____ Date: _____ Witness: _____ Date: _____

Card:#_____ Expiration Date: _____ Security Code:____ Name on card: _____

SHORT CHIROPRACTIC INC PATIENT CONSENT

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

By signing this Consent, I acknowledge and agree as follows:

1. I have been ask if I would like a Privacy Notice *(HIPPA Policy)*, provided to me prior to signing this consent. The Privacy notice includes a complete description of the uses and/or disclosures of my protected health information. **PROTECTED HEALTH INFORMATION** necessary for **SHORT CHIROPRACTIC NC** to provide treatment to me, and also necessary for **SHORT CHIROPRACTIC INC**. to obtain payment for that treatment and to carry out this health care operations. **SHORT CHIROPRACTIC INC** explained to me that the Privacy Notice will be available to me in the future at my request. **Short Chiropractic Inc**. has further explained my right to obtain a copy of the Privacy Notice Prior to signing this Consent, and has encouraged me to read the privacy Notice Carefully prior to my signing this Consent.
2. **SHORT CHIROPRACTIC INC**. reserves the right to change its privacy practices that are described in its Privacy Notice in accordance with applicable law
3. I understand that, and consent to, the following appointment reminders, newsletters, and birthday cards, that will be used by **SHORT CHIROPRACTIC INC.**
    a. Newsletters, cards, various mailings will be mailed to me at the address provided by me,
    b. Telephoning my home and leaving a message on machine, voice mail or with individual answering the phone.
4. **SHORT CHIROPRACTIC INC**. may use and/or disclose my **PROTECTED HEALTH INFORMATION**(which includes information about my health or condition and the treatment proved to me) in order for **SHORT CHIROPRACTIC INC**. to treat me and obtain payment for that treatment, and as necessary for SHORT CHIROPRACTIC INC. to conduct its specific healthcare operations.
5. I understand that I have a right to request that SHORT CHIROPRACTIC INC. restricted how my **PROTECTED HEALTH INFORMATION** is used and/or disclosed to carry out treatment, payment and/or health care operations. However, **SHORT CHIROPRACTIC INC**. is not required to agree to any restriction that I have requested. If SHORT CHIROPRACTIC INC. agrees to requested restrictions, then the restriction is binding on **SHORT CHIROPRACTIC INC**.
6. I understand that his Consent is valid. I further understand that I have the right to revoke this Consent, in writing at any time for all future transactions, with the understanding that any suck revocation shall not apply to the extent that **SHORT CHIROPRACTIC INC** has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time **SHORT CHIROPRACTIC INC** has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the users and disclosures described to me above and contained in the Privacy Notice, then **SHORT CHIROPRACTIC INC** will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____

Printed name Individual

_____ _____

Signature of Legal Representative Date

SHORT CHIROPRACTIC INC will protect your information as required by HIPPA. You are entitled to a copy at any time upon request . By Initialing this , you are acknowledged that you were offer and/or received a copy of the HIPPA Policy .

_____ _____

Patients Initials. **Date**

SHORT CHIROPRACTIC INC
99 CRACKER BARREL DRIVE SUITE 200
BARBOURSVILLE, WV 25504
304-733-4616 FAX 304-733-4818
BRETT A. SHORT, D.C, DESTINY COOPER,D.C. , ERIC COOOPER, D.C.

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ Last Name:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____/_____