FILE # _____
DATE _____
DOCTOR _____

PATIENT INFORMATION

Ashworth Chiropractic & Acupuncture Clinic™

PATIENT DATA - In order to provide you the best possible care, please complete this form as accurately as possible. All information is strictly CONFIDENTIAL.

First Name:_____ M.I.:_____ Last Name:_____ Email:_____

Address:_____ City:_____ State:_____ Zip:_____

Telephone (home):_____ (work):_____ (cell):_____

Age:_____ Birth Date:_____ Preferred Language:_____

Gender: □ Male □ Female Marital Status: □ Single □ Married □ Widowed □ Other Spouse's Name:_____

Race: □ American Indian or Alaskan Native □ Asian □ Black or African American Ethnicity: □ Hispanic or Latino □ Decline
□ Native Hawaiian or Other Pacific Islander □ Other □ White □ Decline □ Not Hispanic or Latino

Emergency Contact:_____ Phone #:_____ Relationship:_____

Allow my Emergency Contact access to my Protected Health Information (PHI) and Billing Information (if necessary only): □ Yes □ No

Occupation:_____ Employer/School:_____ Average hours worked per week: _____

How did you hear about us?:_____ Whom may we thank for referring you?:_____

Medical Doctor:_____ Clinic:_____ City:_____

Previous Chiropractic Care? □ Yes □ No Doctor's Name:_____ Date of last adjustment:_____

FINANCIAL INFORMATION/ASSIGNMENT OF BENEFITS - Please provide your insurance card for copy, if applicable.

Payment method: □ Self Pay □ Health Insurance □ Auto Insurance* □ Worker's Compensation* □ Other*

**If you are seeking treatment as result of an auto injury or personal injury claim, please advise the front desk for additional paperwork*

Insurance Carrier:_____ Policy Number:_____ Group Number:_____

Insured's Name_____ Insured's Birth Date:_____ Relationship to Insured:_____

Billing address, if different from above:

Name:_____ *Address*:_____

City:_____ *State*:_____ *Zip*:_____

Payment in full, including any co-pays and/or deductible, is expected at time of service. ***If full payment is not received the card on file will automatically be charged for the remaining balance at the end of each business day unless other arrangements are made in advance****. If you are unable to pay in full, we will be happy to review our payment plan options with you.*

Our office will make every attempt to verify your policy benefits, however, this office and your insurance **DO NOT** guarantee a quote of benefits for payment of services provided. Should your insurance provide chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance will likely pay within 45 days from the date in which it was filed. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier. **If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.**

ASSIGNMENT AND CONVEYANCE OF LIEN INTEREST - Personal Injury, Auto Accident or Worker's Compensation only

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am entitled, and from which I am to pay in the form of an insurance settlement(s), claim(s), judgment(s), or verdict(s) resulting from any identified accident. The insurance carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds to bills submitted by the doctor and/or treating facility, shall be paid directly to the above named doctor and/or treating facility. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable to my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt of my settlement award(s).

_____ _____

Patient (or Guardian) Signature Date

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) CONSENT

Your Protected Health Information will be used by this office or disclosed to others for purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed; it describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the front desk. This office reserves the right to modify the privacy practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information: you may request a restriction on the use or disclosure of your Protected Health Information. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his or her Protected Health Information for the purposes of treatment, payment, or health care operations. Use or disclosure of Protected Health Information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent: you may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

□ I, _____(print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my health information in accordance with it.

OR

□ I, _____(print) acknowledge that I have reviewed the above information and DO NOT give my permission to release any information to my insurance carrier. I do understand that PHI will be used within the office for purposes of my care to those individuals designated by the doctor.

_____ _____

Patient (or Guardian) Signature Date

INFORMED CONSENT TO TREATMENT

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care, or any clinical services he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following acupuncture treatment, laser therapy, chiropractic manipulation, and/or manual therapy techniques. The risks of complications due to chiropractic or acupuncture treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare". The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the doctor's attention it is your responsibility to inform the doctor.

_____ _____

Patient (or Guardian) Signature Date

CONSENT TO TREATMENT OF A MINOR - If applicable.

As of this date, I have the legal right to select and authorize heath care services for the minor child named above. If applicable, under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse, or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

I authorize the above named minor child to receive treatment at this office when I am not present. □ Yes □ No

_____ _____ _____

Relationship to Child Parent or Guardian Signature Date

FILE # ____________
DATE ____________
DOCTOR __________

PATIENT HEALTH HISTORY

Ashworth Chiropractic & Acupuncture Clinic™

PATIENT DATA – In order to provide you the best possible care, please complete this form as accurately as possible. All information is strictly CONFIDENTIAL.

First Name:___________________ M.I.:_____ Last Name:______________________________ Age:________ Gender: ☐ Male ☐ Female

Previous Chiropractic Care? ☐ Yes ☐ No Doctor's Name:_____________________________ Date of last adjustment:_______________

REASON FOR THIS VISIT

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint

The primary symptom that prompted me to seek care today is:

____
____
____

Complaint is the result of:

☐ An accident or injury:
☐ Work ☐ Auto ☐ Other ____________
____

☐ A worsening long-term problem

Onset: When did you first notice your current symptoms? ________________________

Intensity of Pain:

no pain 1 2 3 4 5 6 7 8 9 10 *worst*

How often do you have this pain (circle)?

Intermittent - Occasional - Frequent- Constant

What type of pain (circle all that apply)?

Sharp - Dull - Achy - Burning - Numbness

Radiating - Stiffness - Shooting - Spasm

Prior Interventions: What have you tried to relieve the symptoms?

☐ Prescription medication
☐ Over-the-counter drugs
☐ Homeopathic remedies
☐ Physical therapy
☐ X-ray/MRI/CAT
☐ Other ________________________
☐ Acupuncture
☐ Chiropractic
☐ Massage
☐ Ice/Heat
☐ Surgery
____

Secondary Complaint

The secondary symptom that prompted me to seek care today is:

____
____
____

Complaint is the result of:

☐ An accident or injury:
☐ Work ☐ Auto ☐ Other ____________
____

☐ A worsening long-term problem

Onset: When did you first notice your current symptoms? ________________________

Intensity of Pain:

no pain 1 2 3 4 5 6 7 8 9 10 *worst*

How often do you have this pain (circle)?

Intermittent - Occasional - Frequent- Constant

What type of pain (circle all that apply)?

Sharp - Dull - Achy - Burning - Numbness

Radiating - Stiffness - Shooting - Spasm

Prior Interventions: What have you tried to relieve the symptoms?

☐ Prescription medication
☐ Over-the-counter drugs
☐ Homeopathic remedies
☐ Physical therapy
☐ X-ray/MRI/CAT
☐ Other ________________________
☐ Acupuncture
☐ Chiropractic
☐ Massage
☐ Ice/Heat
☐ Surgery
____

Additional Complaint

The additional symptom that prompted me to seek care today is:

____
____
____

Complaint is the result of:

☐ An accident or injury:
☐ Work ☐ Auto ☐ Other ____________
____

☐ A worsening long-term problem

Onset: When did you first notice your current symptoms? ________________________

Intensity of Pain:

no pain 1 2 3 4 5 6 7 8 9 10 *worst*

How often do you have this pain (circle)?

Intermittent - Occasional - Frequent- Constant

What type of pain (circle all that apply)?

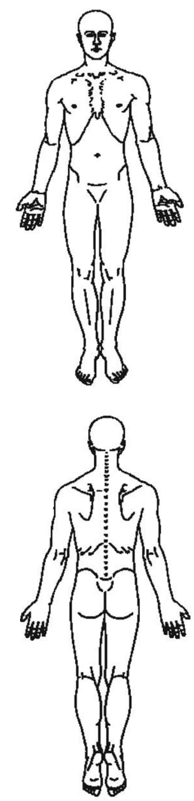
Sharp - Dull - Achy - Burning - Numbness

Radiating - Stiffness - Shooting - Spasm

Prior Interventions: What have you tried to relieve the symptoms?

☐ Prescription medication
☐ Over-the-counter drugs
☐ Homeopathic remedies
☐ Physical therapy
☐ X-ray/MRI/CAT
☐ Other ________________________
☐ Acupuncture
☐ Chiropractic
☐ Massage
☐ Ice/Heat
☐ Surgery
____

Location: Where does it hurt? *Circle the areas on the illustration.*



What else should we know about your current condition?: ____
____

How does your current condition interfere with your life and ability to function?:

	0 - No Effect	1 - Mild Effect	2 - Moderate Effect	3 - Severe Effect
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐
Getting in/out of bed	☐	☐	☐	☐

	0 - No Effect	1 - Mild Effect	2 - Moderate Effect	3 - Severe Effect
Household chores	☐	☐	☐	☐
Lifting Objects	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Exercising	☐	☐	☐	☐

PAST HISTORY

Problem List: *Please mark any condition that you HAD or currently HAVE.*

Neurological		*Cardiovascular*		*Respiratory*		*Digestive*		*Musculoskeletal*		*Sensory*	
Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
□	□ Anxiety	□	□ High blood pressure	□	□ Asthma	□	□ Anorexia/Bulimia	□	□ Osteoporosis	□	□ Blurred vision
□	□ Depression	□	□ Low blood pressure	□	□ Apnea	□	□ Ulcer	□	□ Arthritis	□	□ Ringing in ears
□	□ Headache	□	□ High cholesterol	□	□ Emphysema	□	□ Food sensitivities	□	□ Scoliosis	□	□ Hearing loss
□	□ Dizziness	□	□ Poor circulation	□	□ Hay fever	□	□ Heartburn	□	□ Neck pain	□	□ Chronic ear infection
□	□ Pins & Needles	□	□ Angina	□	□ Shortness of breath	□	□ Constipation	□	□ Back problems	□	□ Loss of smell
□	□ Numbness	□	□ Excessive bruising	□	□ Pneumonia	□	□ Diarrhea	□	□ Hip disorders	□	□ Loss of taste
□ **NONE**		□ **NONE**		□ **NONE**		□ **NONE**		□	□ Knee injuries	□ **NONE**	
								□	□ Foot/ankle pain		
								□	□ Shoulder problems		
								□	□ Elbow/wrist pain		
								□	□ TMJ issues		
								□	□ Poor posture		
								□ **NONE**			

Skin		*Endocrine*		*Genitourinary*		*Constitutional*	
Had	Have	Had	Have	Had	Have	Had	Have
□	□ Skin cancer	□	□ Thyroid issues	□	□ Kidney stones	□	□ Fainting
□	□ Psoriasis	□	□ Immune disorders	□	□ Infertility	□	□ Low libido
□	□ Eczema	□	□ Hypoglycemia	□	□ Bedwetting	□	□ Poor appetite
□	□ Acne	□	□ Frequent infection	□	□ Prostate issues	□	□ Fatigue
□	□ Hair loss	□	□ Swollen glands	□	□ Erectile dysfunction	□	□ Sudden weight change
□	□ Rash	□	□ Low energy	□	□ PMS symptoms	□	□ Weakness
□ **NONE**		□ **NONE**		□ **NONE**		□ **NONE**	

Currently Pregnant: □ Yes □ No *If yes,* Due date:_____ *Please list any current or previous pregnancy complications.*

_____

Illnesses: *Please mark any illnesses that you HAD or currently HAVE.*

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
□	□	AIDS	□	□	Diabetes	□	□	Hepatitis	□	□	Polio	□	□	Typhoid fever
□	□	Alcoholism	□	□	Epilepsy	□	□	HIV Positive	□	□	Rheumatic fever	□	□	Ulcer
□	□	Allergies	□	□	Glaucoma	□	□	Malaria	□	□	Scarlet fever	□	□	Other_____
□	□	Arteriosclerosis	□	□	Goiter	□	□	Measles	□	□	Sexually transmitted disease			
□	□	Cancer*	□	□	Gout	□	□	Multiple Sclerosis	□	□	Stroke			
□	□	Chicken pox	□	□	Heart disease	□	□	Mumps	□	□	Tuberculosis			

**Cancer*: Type: _____ Treatment: _____ Duration: _____

Remission: □ Yes □ No Date of last evaluation: _____ Next scheduled PET/CT/etc.: _____

Treatments: *Please mark any treatments you have received in the PAST or are NOW receiving currently.*

Past	Now		Past	Now		Past	Now		Past	Now		Past	Now	
□	□	Acupuncture	□	□	Birth control pills	□	□	Chiropractic care	□	□	Hormone replacement	□	□	Massage therapy
□	□	Antibiotics	□	□	Chemotherapy	□	□	Dialysis	□	□	Inhaler	□	□	Physical therapy

Medications: □ Yes □ No *Please list all prescription, over-the-counter, supplements, vitamins, etc.*_____

_____

Allergies: □ Yes □ No *Please list any allergies to medication, food, or environment.*_____

_____

Surgeries: □ Yes □ No *Please list any operations you have had, including date of procedure.*_____

_____

Injuries: *Please mark any you have experienced.*

□ Fractured or broken a bone □ Spine or nerve disorder □ Knocked unconscious □ Injured in an accident □ Used neck or back bracing

Family History: *Please note any health conditions in your immediate family.*

Relative	Illnesses	Living	Relative	Illnesses	Living
Mother		□ Yes □ No	Sibling 2		□ Yes □ No
Father		□ Yes □ No	Sibling 3		□ Yes □ No
Sibling 1		□ Yes □ No	_____		□ Yes □ No

Please list any other hereditary health issues you are aware of:_____

Social History:

Alcohol use: □ Yes □ No How much? _____ Drug use: □ Yes □ No How much? _____

Caffeine use: □ Yes □ No How much? _____ Exercise: □ Yes □ No How much? _____

Tobacco use: □ Current every day □ Current some day □ Former □ Never

Acknowledgment: *To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.*

_____ _____

Patient (or Guardian) Signature Date

FILE # _____

NAME _____

CONSULTATION NOTES

Height:_____

Weight:_____

BP:_____/_____

Pulse:_____

AGREEMENT OF FINANCIAL RESPONSIBILITY

Ashworth Chiropractic & Acupuncture Clinic™

Patient Name:	Date of Birth:

This form must be signed prior to services being rendered.

I understand that as a patient of Ashworth Chiropractic & Acupuncture Clinic it is my responsibility to know my insurance plan and what benefits are covered, to know if and when a referral is necessary, and to have verified that the provider I am seeking is in network with my plan. Any balance remaining after insurance has paid, is my responsibility in full.

I also understand and acknowledge that Ashworth Chiropractic and Acupuncture Clinic has an established policy for billing all patients for services not covered by their insurance carrier. In accordance with state provider billing guidelines, I have been cautioned that I will be responsible for charges in the following situations:

- ☐ Patient has identified themselves as having active health insurance coverage; however the patient was not eligible for coverage on the actual date(s) of service.
- ☐ Patient has identified themselves as having an active health insurance policy verbally, but does not have current Insurance ID card present. Patient is responsible for all services rendered if it is determined that they are not eligible for benefits on the date(s) of service.
- ☐ Patient has been informed that (a) the doctor accepts or is in network with their insurance provider and (b) the patient is responsible for any services not paid for by their policy.
- ☐ Patient's insurance-covered maximum visit limit has been exceeded based on their specific policy guidelines.
- ☐ For the safety and best interest of all our patients (regardless of coverage or insurance) an initial exam will be done on the first visit to ensure the patient is a good candidate for chiropractic care. This allows the doctor to form a proper diagnosis and treatment plan. Some insurance policies do not cover this exam or may charge a different fee for this exam. The patient will be responsible for any charges incurred and not covered by their policy during this initial exam.
- ☐ *Payment in full, including any co-pays and/or deductible, is expected at time of service.* ***If full payment is not received the card on file will automatically be charged for the remaining balance at the end of each business day unless other arrangements are made in advance****. If you are unable to pay in full, we will be happy to review our payment plan options with you.*

By signing this form, I acknowledge that I have read and understand that I will assume full responsibility for the total billed charge(s) related to any and all non-covered services. I also acknowledge and understand that I do have the right to refuse the required initial exam, however, doing so will be considered a voluntary refusal of treatment or care at this facility.

_____ _____

Patient (or Guardian) Signature Date