Central Chiropractic Center

Date: _____

Patient Information

Name _____ Sex ☐ M ☐ F Birthdate _____
last first middle initial

Address _____
street/p.o. box city state zip

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security # _____

Occupation _____ Work Phone: _____

Primary Phone _____ Email address: _____

Emergency Contact

Name _____ Relationship _____
last middle initial first

Primary Phone _____ Secondary Phone _____

Employer Information

Employer _____

Address _____
street/p.o. box city state zip

Phone _____

Spouse/Parent Information

Name _____ Phone Number: _____

Who may we thank for referring you? _____

Patient Condition

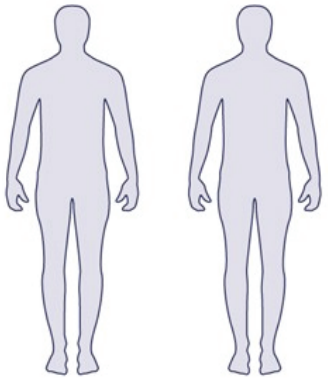
Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? _____

Mark an X on the picture where you experience pain, numbness or tingling.

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



Type of pain (check all that apply) ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching
☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness
☐ Swelling ☐ Other: _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with (check all that apply) ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that area painful to perform (check all that apply) ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Central Chiropractic Center

Health History

What treatment have you already received for this condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition

_____

Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Allergy Shots ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tonsilitis ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tubercolosis ☐ Yes ☐ No
Arthiritis ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No	Tumors/Growths ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No		Typhoid Fever ☐ Yes ☐ No
Bleeding Disorder ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
	Hernia ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	High Colesterol ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	Other
Cancer ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	_____
Cataracts ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Rheumatoid Arthiritis ☐ Yes ☐ No	_____
Chemical Dependency ☐ Yes ☐ No	Measles ☐ Yes ☐ No		
	Migraine Headaches ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No	
Chicken Pox ☐ Yes ☐ No			
Diabetes ☐ Yes ☐ No			

Exercise

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Work Activity

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Habits

☐ Smoking — Packs per day _____
☐ Alcohol — Drinks per week _____
☐ Coffee/Caffeine Drinks — Cups per day _____
☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No if so, Due date: _____

Injuries/Surgeries you have had	description	date
Falls		
Head injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals

Central Chiropractic Center

Insurance Information

** If this is a personal injury assignment, please skip to "Personal Injury Information"*

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Company _____

Member Number_____Group_____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ Social Security Number _____

Relationship to Patient _____

Insurance Company _____

Member Number_____Group_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Damon Butler all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ Date _____

Responsible Party Signature

Relationship to Patient _____

Accident Information

What was the date of the accident?

Type of accident _____ _____

* Personal Injury Information

Attorney Name OR Insurance Adjustor_____

Address _____

Phone _____ Email address:_____ _____

Responsible Insurance Company _____

Claim Number _____

Insured _____

street/p.o. box city state zip

Patient's Auto Insurance Company _____

Primary Phone _____ Email address____ _____

Policy _____

Will will accept assignment from your attorney for your chiropractic treatment. We will supply your attorney with an evaluation of your condition, progress reports, and final evaluation along with your bill. You are responsible for your bill if you dismiss your attorney or if this office is not paid directly by your attorney or the responsible insurance company.

Patient Signature _____ Date _____

Central Chiropractic Center

Patient Health Information Consent

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy or your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature _____ Date _____

PARENT/Guardian's Signature _____ Date _____

Informed Consent for Chiropractic Care

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Central Chiropractic Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient's Signature _____ Date _____

PARENT/Guardian's Signature _____ Date _____

Central Chiropractic Center

Authorization for Release of Medical Records

I hereby authorize Central Chiropractic Center to use and/or disclose all medical records and bills to the entities below:

Requestor Name: _____

_____

_____

_____

Patient's name_____ D.O.A.: _____

Patient Address _____

Date of Birth: _____ SS#: _____

This authorization shall expire upon this expiration date: _____.
If I fail to specify an expiration date, this authorization will expire one (1) year from the date on which it was signed.

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to Central Chiropractic Center. I understand that the revocation will not apply to information that has already been released to this authorization. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may refuse to sign this authorization and it is strictly voluntary.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure of the protected health information as stated.

A photocopy of this authorization is to be accepted and given the same effect as the original.

_____ _____

Signature of Patient/Legal Representative Date

If signed by legal representative, relationship to patient: _____

_____ _____

Signature of Witness Date

Notifier: CENTRAL CHIROPRACTIC CENTER, Damon Butler, D.C., 8755 Sullivan Rd, Ste A, Baton Rouge, LA 70818

Patient Name: **Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **service** below.

Services	Reason Medicare May Not Pay:	Estimated Cost
INITIAL EXAM X RAYS ALL THERAPIES ESTIM, TRACTION, THERAPUTIC EXERCISES ULTRASOUND	MEDICARE WILL NOT PAY FOR ANY CHIROPRACTIC SERVICES LISTED IN BOX D FOR INITIAL VISIT	EXAM- $40 XRAYS - $70 THERAPIES-$10 PER VISIT

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the service listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the service listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the service listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **service l**isted above. I understand with this choice I am **not**

Additional Information: Medicare will only cover 30 visits per year. So any visits to our office over 30 will be charged at $35 per visits. We will notify you when you are 5 visits from your maximum limit. _____ Staff personnel reviewed _____Date

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date:

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