Patient Information

Date _____

SS/HIC/Patient ID # _____

Name _____

Last Name

_____

First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Email Address _____

Sex ◯ Male ◯ Female Age _____

Birthdate _____

◯ Married ◯ Widowed ◯ Single ◯ Minor

◯ Separated ◯ Divorced ◯ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

Phone Numbers

Home Phone _____

Cell Phone _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone _____

Work Phone _____

Insurance

Who is responsible for this account? _____

Relationship to patient: _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ◉ Yes ◯ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to patient _____

Insurance Co. _____

Group # _____

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-names doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

Accident Information

Is this condition due to an accident? ◯ Yes ◯ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

Patient Condition

Reason for visit _____

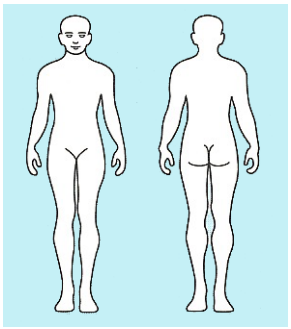
When did your symptoms appear? _____

Is this condition getting progressively worse? ◯ Yes ◯ No ◯ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

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

Type of pain: ☐ 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 your ☐ Work ☐ Sleep ☐ Daily ☐ Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Health History

What treatment have you already received for your 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	Diabetes ◯ Yes ◯ No	Migraine Headaches ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Alcoholism ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	Miscarriage ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Allergy Shots ◯ Yes ◯ No	Epilepsy ◯ Yes ◯ No	Mononucleosis ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Fractures ◯ Yes ◯ No	Multiple Sclerosis ◯ Yes ◯ No	Suicide Attempt ◯ Yes ◯ No
Anorexia ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mumps ◯ Yes ◯ No	Thyroid Problems ◯ Yes ◯ No
Appendicitis ◯ Yes ◯ No	Goiter ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Arthritis ◯ Yes ◯ No	Gonorrhea ◯ Yes ◯ No	Pacemaker ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Gout ◯ Yes ◯ No	Parkinson's Disease ◯ Yes ◯ No	Tumors, Growths ◯ Yes ◯ No
Bleeding ◯ Yes ◯ No	Heart Disease ◯ Yes ◯ No	Pinched Nerve ◯ Yes ◯ No	Typhoid Fever ◯ Yes ◯ No
Disorders ◯ Yes ◯ No	Hepatitis ◯ Yes ◯ No	Pneumonia ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Breast Lump ◯ Yes ◯ No	Herniated Disk ◯ Yes ◯ No	Polio ◯ Yes ◯ No	Vaginal Infections ◯ Yes ◯ No
Bronchitis ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Prostate Problem ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Bulimia ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Prosthesis ◯ Yes ◯ No	Whooping Cough ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Kidney Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Other _____
Cataracts ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Rheumatoid ◯ Yes ◯ No	_____
Measles ◯ Yes ◯ No	Arthritis ◯ Yes ◯ No	Chicken Pox ◯ Yes ◯ No	_____
Chemical Dependency ◯ Yes ◯ No			

Exercise
◯ None
◯ Moderate
◯ Daily
◯ Heavy

Work Activity
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Habits
☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant: ◯ Yes ◯ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy Name _____		
Pharmacy Phone _____		

Young Chiropractic & Acupuncture Center
Nancy Lee Young, D.C.

Symptom # 1

~ On a scale of 1 to 10, with 10 being the worst, please select the number that best describes the symptoms most of the time: ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

~ What percentage of the time you are awake do you experience the above symptoms at the above intensity (select one):
◯0 ◯5 ◯10 ◯15 ◯20 ◯25 ◯30 ◯35 ◯40 ◯45 ◯50 ◯55 ◯60 ◯65 ◯70 ◯75 ◯80 ◯85 ◯90 ◯95 ◯100

~ When did the symptoms begin?_____ Suddenly ◯ Gradually ◯

~ How did the symptoms begin?_____

~ What makes the symptoms worse? (Check all that apply):
☐ Bending neck forward ☐ Bending neck backward ☐ Tilting head to right ☐ Tilting head to left
☐ Turning head to right ☐ Turning head to left ☐ Bending forward at waist ☐ Bending backward at waist
☐ Leaning left at waist ☐ Leaning right at waist ☐ Sitting ☐ Standing ☐ Getting up from sitting ☐ Lifting
☐ Reaching ☐ Driving ☐ Walking ☐ Running ☐ Stairs Other _____

_____

~ What makes it better? (Check all that apply):
☐ Rest ☐ Ice ☐ Heat ☐ Stretching ☐ Exercise ☐ Massage ☐ Pain medication ☐ Muscle relaxors
Other_____

~ Describe the quality of the symptom (Check all that apply):
☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Throbbing ☐ Piercing ☐ Stabbing ☐ Deep nagging
☐ Tingling pressure Other _____

~ Does the symptom radiate to another part of your body? ◯ Yes ◯ No If so, Where? _____

~ Is the symptom worse at certain times of the day or night? (select one)
◯ Morning ◯ Afternoon ◯ Evening ◯ Night ◯ Only at Work ◯ Unaffected by the time of Day

Symptom # 2

~ On a scale of 1 to 10, with 10 being the worst, please select the number that best describes the symptoms most of the time: ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

~ What percentage of the time you are awake do you experience the above symptoms at the above intensity (select one):
◯0 ◯5 ◯10 ◯15 ◯20 ◯25 ◯30 ◯35 ◯40 ◯45 ◯50 ◯55 ◯60 ◯65 ◯70 ◯75 ◯80 ◯85 ◯90 ◯95 ◯100

~ When did the symptoms begin?_ _____ ◯ Suddenly ◯ Gradually

~ How did the symptoms begin?_____

~ What makes the symptoms worse? (Check all that apply):
☐ Bending neck forward ☐ Bending neck backward ☐ Tilting head to right ☐ Tilting head to left
☐ Turning head to right ☐ Turning head to left ☐ Bending forward at waist ☐ Bending backward at waist
☐ Leaning left at waist ☐ Leaning right at waist ☐ Sitting ☐ Standing ☐ Getting up from sitting ☐ Lifting
☐ Reaching ☐ Driving ☐ Walking ☐ Running ☐ Stairs Other _____

_____

~ What makes it better? (Check all that apply):
☐ Rest ☐ Ice ☐ Heat ☐ Stretching ☐ Exercise ☐ Massage ☐ Pain medication ☐ Muscle relaxors
Other_____

~ Describe the quality of the symptom (Check all that apply):
☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Throbbing ☐ Piercing ☐ Stabbing ☐ Deep nagging
☐ Tingling pressure Other _____

~ Does the symptom radiate to another part of your body? ◯ Yes ◯ No If so, Where? _____

~ Is the symptom worse at certain times of the day or night? (select one)
◯ Morning ◯ Afternoon ◯ Evening ◯ Night ◯ Only at Work ◯ Unaffected by the time of Day

Young Chiropractic / Acupuncture Center

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. Protected Health Information is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosure of Protected Health Information:
Your protected health information may be used and disclosed by your physician, the staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, marketing, fund raising activities and conduction or arranging for other business activities. In addition, we may use a sign in sheet at the front desk where you will be asked to sign your name and information. We may also call you by name while you are in the waiting room when your treatment is ready to begin. We may use or disclose your protected health information, as necessary, to contact you to remind you or your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations includes as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

<u>OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.</u>

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name

314-781-7336 / fax 314-781-4241 / www.stlcitychiro.com

Young Chiropractic / Acupuncture Center

Due to the new federal privacy regulations we cannot leave messages with protected health information on home answering machines or with family members no can we contact your family physician if we feel a medical emergency without written permission.

I give Young Chiropractic & Acupuncture Center permission to leave messages:

☐ On my home answering machine/voice mail # _____
☐ On my work answering machine/voice mail # _____
☐ With the person(s) listed – name and relationship

_____

_____

_____

Primary Care Physician_____ Telephone # _____

_____
Signature

_____
Date

☐ I do not want any medical information released except personally to myself.

_____ _____
Signature Date

Young Chiropractic
& Acupuncture Center
Telephone: (314) 781-7336

SIGNATURE ON FILE

- ☐ I authorize the doctor named above to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.
- ☐ I authorize release of any information related to any claims to all my Insurance Companies or other relevant parties.
- ☐ I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me.
- ☐ I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.
- ☐ I authorize payment of health benefits otherwise payable to me, directly to my doctor.
- ☐ I permit a copy of this authorization to be used in place of the original.

This "Signature on File" is valid for one year from the date indicated below.

_____	_____	_____
Signature of Beneficiary, Guardian or Personal Representative	Medicare # (if applicable)	Date

_____	_____
Please print name of Beneficiary, Guardian or Personal Representative	Relationship to Beneficiary

(Vers. M2HSS04)

Patient Billing Acknowledgement Form
Non-Covered Services

Under your health plan, you are financially responsible for copayments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. For example, this may include items such as vitamins or certain chiropractic supplies.

The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products.

PROVIDER: Nancy Lee Young, D.C.
Services to be provided:

☐ Chiropractic Supply **Lumbar support/elbow brace/heel lift**
☐ Therapy **97124/97112/97810**
Other _____

Time frame from _____ Through _____

Schedule/details _____

Provider Signature: _____

Patient:

I, _____ (patient name), acknowledge that I have been told in advance by my provider that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature_____ **Date:** _____

Young Chiropractic Acupuncture Center

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AT YOUNG CHIROPRACTIC & ACUPUNCTURE CENTER

I hereby request and consent to the performance of chiropractic treatment (adjustments/manipulation) and any other associated procedures: Acupuncture, physical examinations, tests, physiotherapy, physical medicine, physical therapy procedures, etc. on me by Nancy Lee Young, D.C.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscular strain, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stoke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure (s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor named above ane /or with the office personnel the nature , purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments. By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatments at the health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition (s) and for any future condition (s) for which I seek treatment by Nancy Lee Young, D.C.

Sign only after you Understand and Agree to the above.

Print name_____

Signature of Patient and Date_____

Signature of Representative and Date_____

Witness to Patient's signature and Date_____

314-781-7336 / fax 314-781-4241 / www.stlcitychiro.com