Confidential Patient Health Record

DATE	I.D. NO.

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ State _____ Zip Code: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: ☐ M ☐ F

Cell Phone: _____ E-mail Address: _____

Social Security # _____ Driver's License Number: _____

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Business Employer: _____ Type of Work: _____

Business Phone: _____

Name of Spouse _____ Spouse's Social Security # _____

Spouse's Employer _____ Business Phone _____

Type of Work _____ Name and Ages of Children _____

Referred To This Office By: _____ _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who Is Responsible For Your Bill, ☐ Me ☐ Spouse ☐ Workers' Comp. ☐ Auto Insurance ☐ Medicare ☐ Medicaid

☐ Personal Health Insurance (Name) _____ ☐ Health Card # _____

Insured Person's Name _____ Date of Birth _____

CURRENT HEALTH CONDITION

Unwanted Health Condition _____

Other Doctors Seen For This Condition: ☐ Yes ☐ No ____ Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? ☐ Yes ☐ No

Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____

Date of Accident: _____ Time of Accident: _____

Have You Made A Report of Your Accident To Your Employer: ☐ Yes ☐ No

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine

☐ Insulin ☐ Other _____

Do You Wear A Shoe Lift? ☐ Yes ☐ No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

_____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other _____

Major Accident or Falls: _____

_____

Hospitalization (Other Than Above): _____

_____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

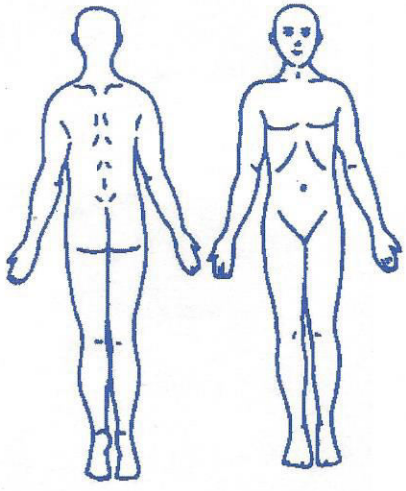
MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FEMALES ONLY:

When was your last period?_____

Are you pregnant?
☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

_____
Doctor's Signature

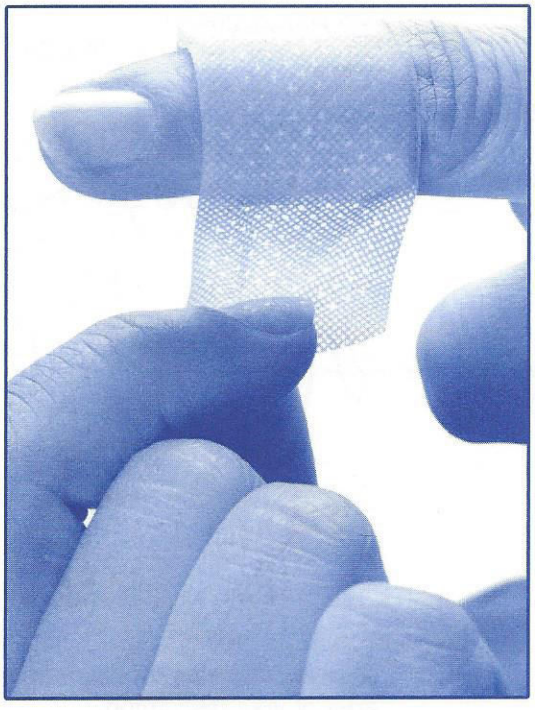
Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Check here if you want the Doctor to select the type of care appropriate for your condition

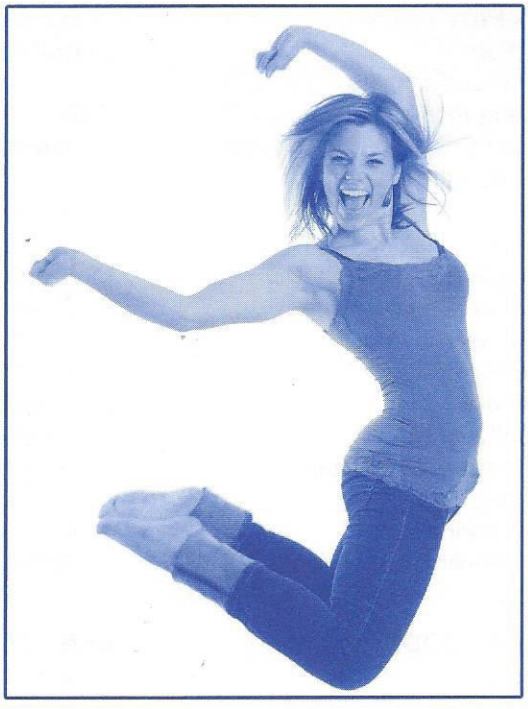
Date _____ Patient's Signature _____

If this is an accident related injury, please fill out the Accident Form. Thank You!



Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature _____ *Date* _____

Consent to Treat a Minor _____ *Date* _____

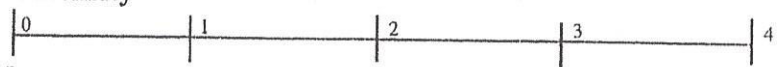
Guardian or Spouse's Signature of Authorizing Care _____ *Date* _____

Functional Rating Index

For use with Neck and/or Back Problems only.

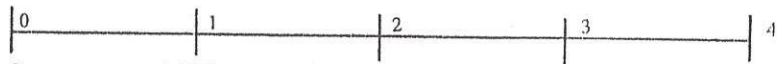
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



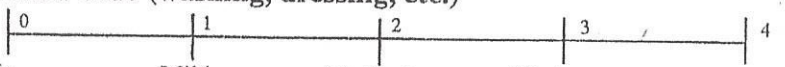
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



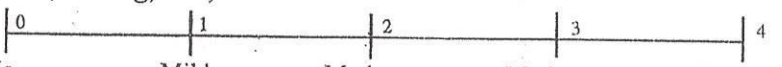
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



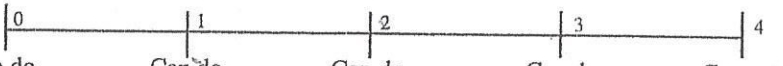
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



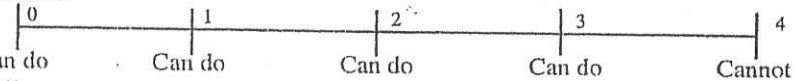
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



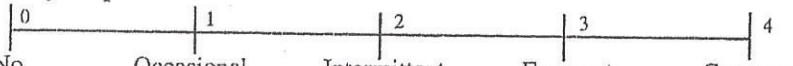
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



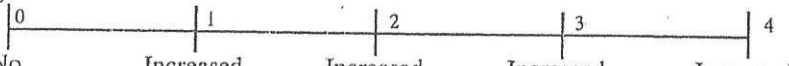
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



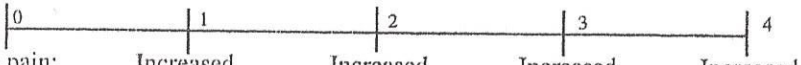
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



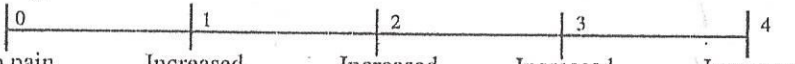
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ **ID#/SS#** _____ **Plan ID.** _____ **Total Score** _____

PRINTED

_____

Signature

_____

Date

ANDREW C. KIRK, D.C.
KIRK CHIROPRACTIC CENTER
5707 ABERCORN STREET
SAVANNAH, GEORGIA 31405
(912) 354-5073 FAX (912) 354-4221

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance, carrier, Workers' Compensation carrier or State Bureau, or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to Advantage Radiological Services (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them or their agents to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and assign my insurance benefits as described above.

SIGNATURE:_____

DATE: _____

WITNESS: _____

Kirk Chiropractic Center
Pearson Chiropractic
Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of 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.

1. The patient understands and agrees to allow this Chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this Chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patients written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.
5. For your security and the right to privacy, all staff have been trained in the area of patient record privacy and a privacy official had been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, our office has the right to refuse to give care.

I have read and understood how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Name of Patient **Date**

Kirk Chiropractic Center
Pearson Chiropractic
5707 Abercorn Street
Savannah, GA 31405
(912) 354-5073 (T)
(912) 354-4221 (F)

Informed Consent for Chiropractic

Chiropractic care, like all forms of health care, while offering benefits may also provide some level of risk. This level of risk is most often minimal, yet in rare caese the injury has been associated with Chiropractic care. The types of complications that have been reported secondary to Chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely fractures. One of the rarest complications associated with Chiropractic care, occurring at a rate between one instant per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke.

Prior to receiving Chiropractic care at this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health, and your spine. These procedures will assist us in determining if Chiropractic care is needed or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with Chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the Chiropractic care, including spinal adjustments, as reported following my assessment.

Patient Name:_____

Date:_____

Parent or Legal Guardian Signature:_____

Witness/Employee of Kirk Chiropractic:_____

Date:_____

Andrew C. Kirk, D.C./ Jonathan A. Pearson, D.C.
Kirk Chiropractic Center/ Pearson Chiropractic
5707 Abercorn Street
Savannah, GA 31405
(912)354-5073 (T) (912)354-4221 (F)

Our Financial Policy

Thank you for choosing our office as your Health provider. We are committed to your treatment being a success. Please understand that payment of your account is considered part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to, and sign prior to any treatment.

****All patients must complete our Patient Information.**
****Full payment of balance or co-pay, which ever should apply, is due at the time of service.**
****We accept cash, check, or charge cards: Visa, Mastercard, American Express, and Discover.**
****In the event that we would receive a returned check, there will be a $35.00 fee charged to your account, thereafter cash and charge cards will only be accepted.**

Regarding Insured Patients

Your first office visit must be paid in full at the time of service. However, we will be happy to accept assignment of your insurance benefits upon verification of Chiropractic coverage. We offer to file your insurance as a courtesy, you will be required to pay your percentage of insurance at the time of each office visit. In the event your insurance company has not paid on your account in full within 60 days, the balance then becomes the patient's responsibility. Please be aware some and maybe perhaps all of the services provided have a chance of being "non-covered" services per your insurance policy. If that would be the case, it then becomes the patient's responsibility to pay in full.

Regarding Un-insured Patients

Patients that have no insurance or whose insurance does not cover Chiropractic care, will personally be responsible for payment. Payments must be made at the time of service or on the last visit of each week. Arrangements must be made with front desk staff to ensure an accurate account. Please understand that our office does not bill patients, we expect payment due upon date of service. As a service to you and to keep your account current, any balance or agreed upon payments not paid on the agreed date, will automatically be charged to the designated card of your choice below. We offer a special program to all of our "un-insured" patients or those whose insurance does not cover Chiropractic care. Ask the front desk staff about our program called Chiropractic Access Program.

WE OFFER WAYS TO MAKE CHIROPRACTIC CARE AFFORDABLE FOR JUST ABOUT EVERYONE!!!

****

****

Credit Card: American Express___ Visa___ Mastercard___ Discover___
Card Holder Name:_____ Card Number:_____
Expiration Date:_____
I agree to the above terms and authorize this office to charge any payment not paid as agreed to the above credit card.

Signature:_____ Date:_____

****

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read, understood, and agreed to the above financial policy.

Signature:_____ Date:_____

Andrew C. Kirk, D.C./ Jonathan A. Pearson, D.C.
Kirk Chiropractic Center/ Pearson Chiropractic
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Savannah, GA 31405
(912)354-5073 (T) (912)354-4221 (F)

Insurance Assignment Policy

You have selected "Insurance Assignment" as the method of choice to take care of your financial obligation with this office. It is important that you realize that in this office we offer the option of "Insurance Assignment" strictly as a courtesy to our patients, and as such, our patients must understand and agree to the following:

1. That you are ultimately responsible for full payment of any and all services rendered including the deductible.
2. That your percentage must be paid at the time of service, or at the end of each week made with prior arrangements.
3. That if your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim and that after 90 days you will be responsible for payment in full for any outstanding balance.
4. Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.
5. That in the event you discontinue your care without the Doctor's authorization, you are responsible for payment in full of any outstanding balance, even if your insurance has been filed. (If the insurance does pay, it will be refunded to you if you have a zero balance.)

I understand and agree with all of the above policies and authorize this office to accept "Insurance Assignment."

Signature **Date** **Witness** **Date**

Authorization To Release Information

I authorize Dr. Kirk/Dr. Pearson and staff named below to release or receive any information deemed appropriate concerning my physical condition to or from any physician, insurance company, attorney, or adjuster in order to process any claim for reimbursement of charged incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a Photostat copy of this agreement shall serve as the original.

Signature **Date** **Witness** **Date**