Confidential Patient Health Record

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Cell Phone _____

SS# _____-_____-_____ # Children _____

Employer _____

Occupation _____

Primary insurance _____

Subscriber date of birth _____

Sex: M F Marital Status: M S W D

Date of Birth: _____ Age: _____

Spouse Name _____

Referred By _____

Reason for choosing our office: _____

_____

Work Phone _____

Family Physician: _____

Secondary Insurance _____

Subscriber date of birth _____

Was this accident / injury result of: Auto Work Other

Date of Injury: _____

Describe injury or complaint and what you think caused it:

_____

_____

_____

_____

List other doctors consulted for this condition(s):

Doctor's Name: _____

When Consulted? _____ Diagnosis _____

Treatment: _____

List serious accidents, falls, or broken bones: _____

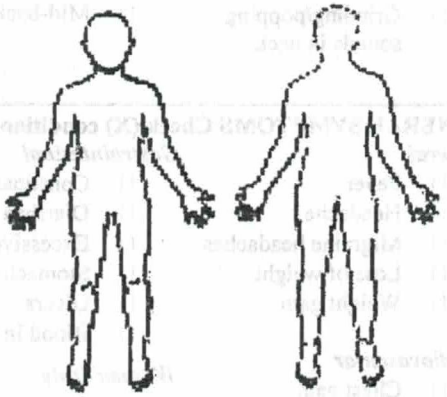
_____ When? _____

Were you ever knocked unconscious? Yes No

Explain: _____

Mark with an X where the pain is located

Front Back



Put an X on the number that best describes the level of your pain

0 1 2 3 4 5 6 7 8 9 10

No Pain Mid Pain Moderate Pain Severe Pain

Habits

Have you ever smoked? Yes No

Smoking _____ packs/day _____years

Alcoholic beverages _____ per week

Coffee _____ cups per day

Sleep _____ hours per night

Exercise _____ times per week

Family History

Put an X on the appropriate Line

	Diabetes	Heart	Kidney	Cancer	Back
Father	___	___	___	___	___
Mother	___	___	___	___	___
Brother	___	___	___	___	___
Brother No of ___	___	___	___	___	___
Sister No of ___	___	___	___	___	___

Please list the medications and vitamins or food supplements you are taking:

(including prescription drugs, birth control, and over the counter drugs like aspirin, cough syrup, etc.)

1. _____ For: _____ Approximately how long? _____
2. _____ For: _____ Approximately how long? _____
3. _____ For: _____ Approximately how long? _____
4. _____ For: _____ Approximately how long? _____
5. _____ For: _____ Approximately how long? _____

List Allergies: (medicine, dust, ragweed, certain foods)

1. 2.

3. 4.

Check (X) any of the following illnesses or diseases you have or have had:

☐ Diabetes	☐ Chicken pox	☐ High cholesterol	☐ Arthritis
☐ Cancer	☐ Polio	☐ Tuberculosis	☐ Influenza
☐ Heart Attack	☐ Appendicitis	☐ Rheumatoid arthritis	☐ Whooping cough
☐ Stroke	☐ Chronic cough	☐ Anemia	☐ Epilepsy
☐ Kidney Stones	☐ Measles	☐ Goiter	☐ Pleurisy
☐ Prostate problems	☐ Mumps	☐ Osteoporosis	☐ Pneumoni

NECK, BACK, EXTREMITY Check (X) conditions you presently have or have had in the <u>past year</u>.

Neck & Shoulders
- ☐ Pain in neck
- ☐ Neck Stiffness
- ☐ Grinding/popping sounds in neck

Mid-Back
- ☐ Mid-back pain
- ☐ Pain between shoulder blades
- ☐ Mid-back stiffness

Arms & Hands
- ☐ Pain down arm
- ☐ Pain/numbness in hand

Low Back
- ☐ Low back pain
- ☐ Low back stiffness

Hips, Legs & Feet
- ☐ Pain in buttocks
- ☐ Pain/numbness down leg

GENERAL SYMPTOMS Check (X) conditions you presently have or have had in the <u>past year</u>.

General
- ☐ Fever
- ☐ Headache
- ☐ Migraine headaches
- ☐ Loss of weight
- ☐ Weight gain

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure

Gastrointesinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Stomach pain
- ☐ Ulcers
- ☐ Blood in stool

Women Only
- ☐ Menstrual pain
- ☐ Abnormal bleeding

Eyes, Ear, Nose, Throat
- ☐ Blurred vision
- ☐ Earache
- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Nosebleeds
- ☐ Dizziness

Are you pregnant? ☐ Yes ☐ No ☐ Maybe

☐ Menopause

Genito-Urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Painful irination
- ☐ Difficulty starting and/or stopping urine

Please list the surgeries and hospitalizations that you have had and their appropriate dates:

1.	Date:	Doctor:
2.	Date:	Doctor:
3.	Date:	Doctor:
4.	Date:	Doctor:

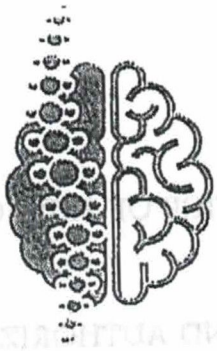
List past illnesses: (heart attack, thyroid, kidney, etc.)

1.	Date:	Doctor:
2.	Date:	Doctor:

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and me, not between my insurance and this office. If there is a deductible co-pay, or percentage coverage – I agree to pay my portion as services rendered, unless other arrangements have been made. However, I understand that I am ultimately responsible for payment in full at this office. In the event default payment of any amount due, and if this account is placed in the hands of a collection agency or attorney for collection or legal action, I agree to pay an additional charge equal to the cost of collection including collection agency and attorney fees and court costs incurred.

Patient Signature _____ Date _____

Parent or Guardian's Signature Authorizing Care _____ Date _____



Feel the Difference!

DOUBLEDAY'S

Spine & BRAIN

OF SOUTHWEST MICHIGAN

balance • rehabilitation • advanced • integrative • neurology

Dr. Beau Doubleday, D.C,
D.A.C.N.B
Functional Neurologist
Chiropractic Physician
Functional Neuro-Orthopedic
Rehab Specialist
Member of Michigan
Association of Chiropractors
Member of American
Chiropractic Association
Plasticity Brain Center Faculty

Dear Patient:

Our company utilizes a third party collection agency. If your account goes into collections you will be responsible for all collection fees assessed by that third party collection agency.

Thank you for your understanding regarding this matter.

Patient Signature **Date**

601 South Shore Drive
Battle Creek, MI. 49014
Phone: 269-963-3072
Fax: 269-963-3085
Email:
drdoubleday@gmail.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

AND

COMMUNICATION PREFERENCES AND AUTHORIZATION

Please read the following and initial at each paragraph:

_____ I acknowledge that I was provided a copy of the Notice of Privacy Practices (HIPAA). I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices (HIPAA). I understand that this form will be placed in my patient chart and maintained for seven (7) years unless I provide written notice to revoke this authorization. I understand that I have certain rights to privacy regarding my protected health information. I understand that is information can and will be used in the following ways:

- Conduct, plan, and direct my treatment and follow-up among health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

_____ I understand that the staff at Doubleday's Spine & BRAIN of Southwest Michigan may on occasion send me notifications or newsletters via mail or e-mail. I authorize this type of communication to the address and or e-mail address I have provided on my initial paper work.

_____ I understand that Doubleday's Spine & BRAIN of Southwest Michigan utilizes phone calls, text messaging and e-mail messaging for appointment reminders and or missed appointments. I authorize the staff at Doubleday's Spine & BRAIN of Southwest Michigan to contact me with these reminders and leave a voice mail message if necessary.

Patient

Signature Date

Witness Date

FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

_____ INDIVIDUAL REFUSED TO SIGN _____ COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGMENT

_____ AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT _____ OTHER AS SPECIFIED_____

APPOINTMENT CANCELLATION/ NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment at all, or timely, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. In the instance that a standard chiropractic appointment, massage, therapeutic exercises, ultra sound, tapping, or e-stim is not cancelled at least 12 hours in advance we reserve the right to charge a thirty dollar ($30) fee; a new patient or a patient that hasn't been seen by the Doctor in six plus months; or an existing patient with a scheduled exam- a fifty dollar ($50) fee. In the instance that a Neurology Appointment including FNOR is not cancelled within 24 hours we reserve the right to charge a one hundred dollar ($100) fee.

Thank you for understanding.

Name _____

Signature _____ Date _____

Staff/Witness _____ Date _____

Payment Policy

All patients are responsible for full payment at the time of service.

As a courtesy, Doubleday's Spine & BRAIN of Southwest Michigan, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan. If your claim processes differently from the benefits we were quoted, the insurance company will side with the way that the plan processes and will not honor the benefit quote we received. It is the policy of Doubleday's Spine & BRAIN of Southwest Michigan that payment is DUE AT THE TIME OF SERVICE unless other financial arrangements are made in advance. We require all patients to pay their deductible, co-pay, and/or coinsurance payment at the conclusion of each visit. You may be billed for any outstanding balances.

If you are covered by health insurance, we will be happy to bill your insurance. It is the responsibility of the patient to ensure that Doubleday's Spine & BRAIN of Southwest Michigan has the correct insurance information and also to update this information as it changes. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. We do not participate with Blue Care Network (BCN), Priority HMO, or Humana. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover services provided at Doubleday's Spine & BRAIN of Southwest Michigan. Please remember that you are **100%** responsible for all charges incurred and that your physician's referral and our verification of your insurance benefits are not a guarantee of payment. We highly recommend that you also contact your insurance carrier and check into your coverage for chiropractic services, massage (performed by a massage therapist), mechanical/manual traction, myo-facial release, therapeutic exercise, and/or therapeutic exercises/activities, x-ray. We do not bill secondary insurance unless you are a patient that has Medicare as a primary insurance. Do not assume that you will not owe anything if you have more than one insurance policy.

Agreement: By signing this agreement I agree to the terms as outlined in the above paragraphs.

_____

Patients Name/ Date

_____

Staff/Witness/ Date

DISCLOSURE & CONSENT
CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at that time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

_____
Print Name

_____
Signature of Patient

_____
Date Signed

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or physically or legally incapacitated:

_____
Print Name of Patient

_____
Print Name of Patient's Representative

_____
Signature of Patient's Representative

as:_____
Relationship or Authority of Patient's Representative

_____
Date

To be completed by doctor or staff:

_____
Witness to Patient's Signature

_____
Date

_____
Translated by

To be completed by doctor or staff:

_____
Date