ACCESS FAMILY CHIROPRACTIC

Rodney B. Thomas, D.C.

CONFIDENTIAL PATIENT INFORMATION

Dear Patient, Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not believe your condition will respond satisfactorily, we will not accept your case. **Thank you.**

NAME: _____ DATE: _____
CURRENT ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: (H) _____ (W) _____ (C)_____ SSN#: _____
DATE OF BIRTH: _____ AGE: _____ STATUS: S/M/W/D SPOUSE: _____
OF CHILDREN _____ OCCUPATION: _____
E-MAIL: _____

NAME & ADDRESS OF EMPLOYER:
_____
PRIMARY CARE PHYSICIAN: _____
ADDRESS: _____
TEL#: _____
WHOM MAY WE THANK FOR REFERRING YOU? _____
_____

HEALTH INFORMATION
Have you had previous chiropractic care? _____ yes _____ no
Main Complaint _____
Other Complaints _____
Have you had any surgery, falls or accidents? ____ Yes _____no
When? _____ Please describe _____
_____

Date of last physical examination: _____
Date of last spinal x-ray (Medicare Patients): _____

INSURANCE INFORMATION
NAME: _____ SUBSCRIBER: _____
ADDRESS: _____
PHONE: _____ POLICY #: _____
SUBSCRIBER SSN#: _____ - _____ - _____ BIRTHDATE: _____
RELATION TO SUBCRIBER: _____
Is this condition due to:
A work related injury? yes no An automobile accident? yes no
Are you covered by Medicare? ID# _____

I understand I am financially responsible WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my major medical insurance benefits, Medicare, private insurance and other health plans to RODNEY THOMAS, D.C. Any overpayment will be promptly refunded. I also authorize RODNEY THOMAS, D.C. to release any information required to secure payment. If balance becomes delinquent and suit is filed, I agree to pay all collection costs, court costs, and attorney's fees in addition to the above fee. Past due balances will be charged interest of 5% per month.

Patient's Signature: _____ Date _____

Responsible Party: _____ Date _____

DO YOU SUFFER FROM:	YES	NO
Headaches	☐	☐
Neck Pain	☐	☐
Arm Pain	☐	☐
Shoulder Pain	☐	☐
Back Pain	☐	☐
Hip/Leg Pain	☐	☐
Chest Pain	☐	☐
Abdominal Pain	☐	☐
Sinus Trouble	☐	☐
Heart Trouble	☐	☐
Palpitation	☐	☐
Circulation	☐	☐
High or Low Blood Pressure	☐	☐
Female Problem	☐	☐
Prostate disorder	☐	☐
Kidney problems	☐	☐
Bladder problem	☐	☐
Lung/Bronchial Disorder	☐	☐
Digestive Disorder	☐	☐
Constipation	☐	☐
Loose Stool	☐	☐
Diabetes	☐	☐
Swollen Joints	☐	☐
Insomnia	☐	☐
Dizziness	☐	☐
Numbness	☐	☐
Nervousness	☐	☐
Depression	☐	☐
General Fatigue	☐	☐
Morning Fatigue	☐	☐
Anemia	☐	☐
Poor Memory	☐	☐
Hot Flashes	☐	☐

Patient Information Authorization

Access Family Chiropractic Inc.

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records:

- To contact you by phone, e-mail or in writing.
- To leave a message on your answering machine or e-mail.
- To leave a message with person/s (family member, friend, or other) who answers the phone number you gave us.
- To remind you of your treatments / appointments times.
- To send you a “Thank You” card.
- To send you a "Thank You” referral gift certificate.
- To place you on a “Thank You Referring Board” hung in the office.
- To use in testimonials.
- To use in advertising.
- To send you marketing materials.
- To inform you about treatment alternatives.
- To use your picture for a "patient appreciation wall"

If you feel uncomfortable with any of the above and wish it not to be used as stated above, please cross out that line(s) and initial it.

Otherwise, by signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health-care information is released or you may revoke your authorization to us at anytime; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization in writing. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decided to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subjected to re-disclosure by anyone who has access to the remainder or other information and may no longer is protected by the federal privacy rules.

You may have the right to refuse to give us this authorization. If you do not give us this authorization, it will not affect the treatment we provide to you or the method we used to obtain reimbursement for your care.

You may inspect or request a copy the information that we used to contact you or any other use of your personal information or other health related information at anytime(§164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use for disclosed my health information in a manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient Name (print) Date

_____ _____

Patient Signature Authorized Provider Representative

_____ _____

Personal Representative (print) Personal Representative Signature

_____

Description of the personal representative's authority to act for the patient.

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act of* 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Access Family Chiropractic *Notice of Privacy Practices for Protected Health Information.*

_____	_____
Patient Name Printed	Date
_____	_____
Patient Signature	Authorized Provider Rep.
_____	_____
Personal Representative Printed	Personal Representative Signature

Description of personal representative's authority to act for the patient

Access Family Chiropractic, Inc.
770 Carew Street
Springfield, MA 01104

Dr. Rodney B. Thomas Jr. PH (413) 733-1181 • FAX (413) 733-6676

INFORMED CONSENT

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physical therapy and diagnostic x-ray, on me (or on the patient named below, for whom I am legally responsible) by the doctor of Chiropractic named above and/or other license doctors of Chiropractic now or in the future treat me while employed by, working or associate with or servicing as backup for the doctor of Chiropractic named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of Chiropractic named above/or with other office of clinic personnel the nature and purpose of Chiropractic adjustments and procedures. I understand the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of Chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations, and sprains. 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 judgment during the course of the procedure which the doctor feels at that time, based on the facts then known, and is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent, and by signing below I have agreed to the above named procedures. 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.

_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN **DATE**