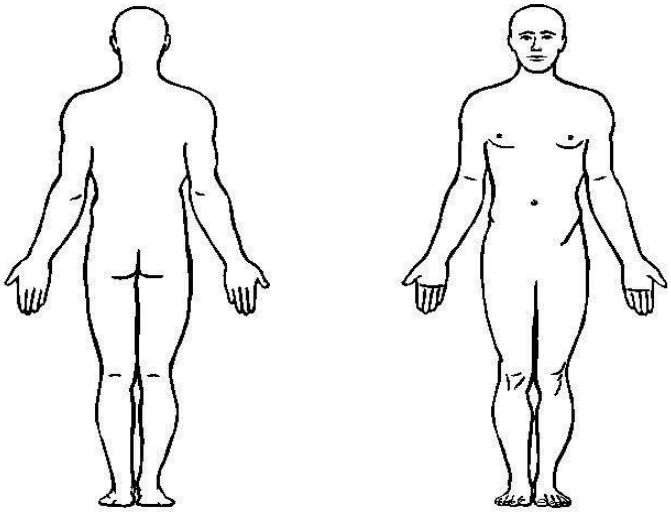
Health History Hazen Chiropractic

NO WORKCOMP / NO PERSONAL INJURY-See Front Desk

Patient's Personal Information	
Name:	DOB: Age:
Street Address:	City, State, Zip:
Home Phone:	Cell Phone:
Email:	Marital Status: ☐ S ☐ M ☐ D ☐ W
Occupation:	Spouse Name: Spouse Number:
Employer:	Name of nearest relative: Phone number:
How did you hear about our office?	

Current Health Conditions	
Please mark on the image your area(s) of complaint. Please number them according to severity.	
When did it start? Is this the result of an Accident or Injury?	How did the problem start? ☐ Sudden ☐ Gradually ☐ Post-Injury ☐ Accident
Have you ever received care for this condition before? ☐ Yes ☐ No If yes, by whom?	Is the pain? ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional
What makes this problem better?	What makes this problem worse?
Please describe the pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Numbness ☐ Tingling ☐ Burning ☐ Stabbing	Please rate your pain on a scale of 1 (no pain) to 10 (worst pain imaginable):

Family History

Father: ☐ Living ☐ Deceased Current age if still living:
Age and cause of death if deceased:

Mother: ☐ Living ☐ Deceased Current age if still living:
Age and cause of death if deceased:

Does anyone in your family suffer from any of the following:

☐ Tuberculosis	☐ Lung Disease	☐ Asthma	☐ Liver Disease
☐ Diabetes	☐ Heart Disease	☐ Arthritis	☐ Cancer
☐ Stroke	☐ Kidney Disease	☐ Mental Illness	

Past Medical & Social History

Do you have a history of stroke or hypertension? ☐ Yes ☐ No

Women are you currently or is there any possiblity that you are pregnant? ☐ Yes ☐ No

What medications/drugs are you currently taking?

Do you have any allergies to medications? ☐ Yes ☐ No
-If yes, please explain:

Have you been treated for any health conditions by a physician in the past year? ☐ Yes ☐ No
-If yes, please explain:

Have you ever been diagnosed as having or have suffered from:

☐ Broken Bones	☐ Stroke	☐ Heart Conditions (please list)
☐ Circulatory Problems	☐ Pace Maker	☐ Alcoholism/ Drug Addiction
☐ Rheumatoid Arthritis	☐ Cancer	☐ Osteoarthritis
☐ Seizures/Convulsions	☐ Depression	☐ High/Low Blood Pressure
☐ A Congenital Disease	☐ Gall Bladder Problems	☐ Excessive Bleeding

Please list any food intolerance or allergies:

Have you had any major illness, injuries, falls, auto accidents or surgeries (please include dates)? Women, please include information about childbirth:

Do you consume alcoholic beverages? ☐ Yes ☐ No -If yes, how much per week?

Do you use any tobacco products? ☐ Yes ☐ No
-If yes how much/many pack per day:

Do you take vitamin supplements? ☐ Yes ☐ No
If yes, please list:

Do you consume caffeine? ☐ Yes ☐ No
If yes, how much per day:

Do you exercise? ☐ Yes ☐ No
-If yes, what is the type and frequence of exercise?

Patient/Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Updated 09/2021

Payment Policy

Hazen Chiropractic

1. Patients are personally responsible for all charges.
   As a non-participating provider, **any portion of services provided, not covered by MEDICARE or your SUPPLIMENTAL insurance, are the responsibility of the patient for the full amount charged.**

2. Our offices file to **MEDICARE ONLY**, provided that industry standard claims process is used. Out of network claims requiring paperwork above and beyond the industry standard process is the responsibility of the patient. Secondary insurance claims will not be processed by our office.

3. The following services/products are standardly denied by insurance companies; the initial exam, ultrasound, laser, pillows, custom orthotics, nutritional consultations, and nutritional supplements.

4. I understand and agree that insurance policies are an arrangement between my insurance company and me – not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports at no charge to assist in collecting from my insurance company.

5. There will be a $35.00 charge for returned checks due to nonsufficient funds (NSF). After one NSFs, checks can no longer be accepted as a method of payment.

6. There is a $2.00 processing fee charged on all Credit/Debit card transactions.

7. This office does not accept Work Comp Claims or Personal injury Claims. **STOP** and see the front desk if this is related to either a work accident, auto accident, or injury that will be filed to a third-party insurance company.

8. Patients can receive one copy of their records at no cost. Additional copies are $50.00.

I HAVE READ, UNDERSTAND, AND AGREE WITH THE PAYMENT POLICY:

PATIENT NAME:_____ DATE: _____

PATIENT SIGNATURE: _____ DATE: _____

Terms & Consent to Hazen Chiropractic

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective as this prevents any confusion or disappointment.

The objective of chiropractic health care in our office is to improve and optimize the health and function of the spine and nervous system through the correction of vertebral subluxations[2]. A chiropractic adjustment[1] is the method used for the correction of the vertebral subluxations.

We do not diagnose or treat any disease. We analyze the spine for vertebral subluxations. If, during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Our commitment to your health is to (1) evaluate and monitor your spine and nervous system on each visit to determine if the adjustment and adjusting procedures that will get the best outcome for you and (2) to provide you with supportive education and information so you can get the best results from our care.

I, _____ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Name: _____ Date: _____

Signature: _____

Consent To Share Photo's

1. I consent to my photo or image being used in photograph or video in public media including social media, website, or promotional materials. If I should withdraw my consent, I will notify the office in writing.
2. I consent to my child's photo or image being used in photograph or video in public media including social media, website, or promotional materials. If I should withdraw my consent, I will notify the office in writing.

Please note below any withdrawal of consent to any of the above statements

Name: _____ Date: _____

Signature: _____

1. Chiropractic Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

2. Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Patient Health Information Consent Form

Hazen Chiropractic

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 HIPAA 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 patient's 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 right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has 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, the chiropractic physician has the right to refuse to give care.
8. I give Hazen Chiropractic Center permission to request any medical records or imaging reports that will additionally aid in my care.

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

Patient Signature Date