

Batesville Spine & Health Solutions

Patient Information

Name: _____ (Age) _____ Gender: M F
Home Address: _____ Home Phone: () _____
City, State, Zip: _____ Work Phone: () _____
Email Address: _____ Cell Phone: () _____
Birth Date: ____/____/____ Social Security #: _____ - ____ - _____ Marital Status: S M D W
Occupation: _____ Employer Name: _____
Spouse's Name: _____ Work Phone: () _____ Cell Phone: () _____
Spouse's Employer: _____ Occupation: _____
How were you referred to this office? _____

Purpose For This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)*? Yes No If yes, when: ____/____/____

**If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.*

Describe: _____

Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your symptoms.

When did these symptoms begin? ____/____/____ Are they: Constant Intermittent Activity-related Are they getting worse? Yes No Do they interfere with: Work Sleep Hobbies Daily Routine

Explain: _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? Yes No If yes, explain: _____

Have you experienced these symptoms before (if not accident/injury related)? Yes No

If yes, explain: _____

Have you been treated for this? Yes No When were you last treated? ____/____/____

Who did you see? _____

What treatment was performed? _____

How did you respond? _____

Experience with Chiropractic

Have you seen a Chiropractor before? Yes No Who? _____

Reason for visit(s): _____

Did your previous chiropractor take 'before' and 'after' x-rays? Yes No What was the diagnosis? _____

Did he or she recommend a specific course of treatment? Yes No Did they recommend a Home Health Care program? Yes No

If yes, what? _____ How long were you treated? _____ Last treatment: ____/____/____

How did you respond? _____

Are you aware of any poor posture habits? Yes No Is there any history of spinal problems in your family? Yes No

If yes, explain: _____

GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE

G = STABBING

N = NUMBNESS

B = BURNING

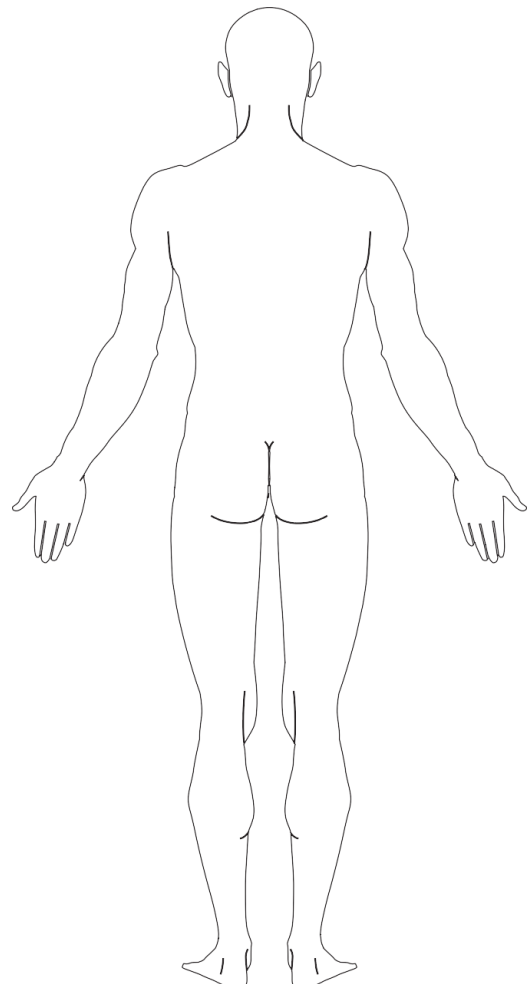
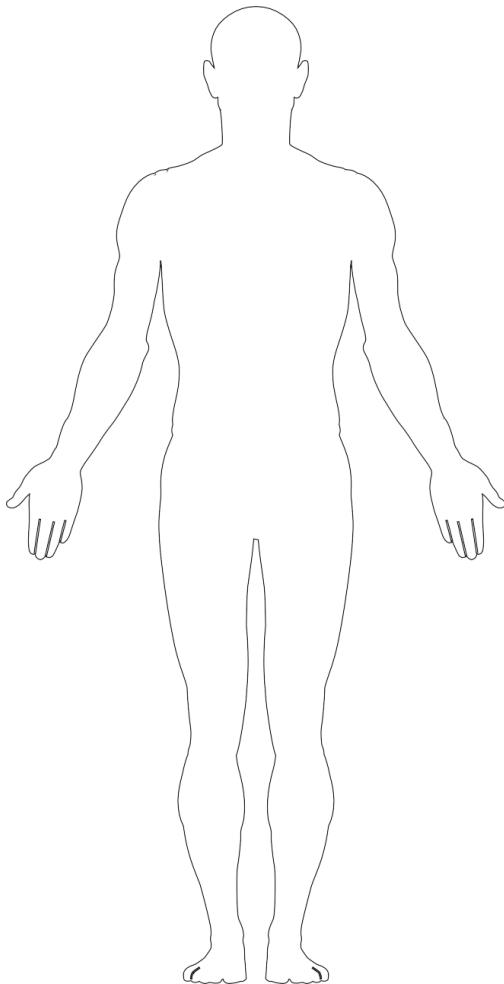
M = SPASMS

T = TINGLING

P = PINS & NEEDLES

F = STIFFNESS

O = OTHER



Health & Lifestyle

Do you exercise? Yes No How often? _____ day(s) per week; Other: _____

What activities? Walking Running/Jogging Weight Training Cycling Yoga Pilates Swimming Other: _____

Do you smoke? Yes No How much? / How often? _____

Do you drink alcohol? Yes No How much? / How often? _____

Do you drink coffee? Yes No How much? / How often? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

If yes, please list: _____

CERVICAL SPINE (NECK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Neck Pain

____ Headaches

____ Sinusitis

____ Pain in shoulders/arms/hands

____ Dizziness

____ Allergies/Hay fever

____ Numbness/tingling in arms/hands

____ Visual disturbances

____ Recurrent colds/Flu

____ Hearing disturbances

____ Coldness in hands

____ Low Energy/Fatigue

____ Weakness in grip

____ Thyroid conditions

____ TMJ/Pain/Clicking

THORACIC SPINE (UPPER BACK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Heart Palpitations

____ Pain in Ribs/Chest

____ Pain On Deep Inspiration/Expiration

____ Heart Murmurs

____ Indigestion/Heartburn/Reflux

____ Nausea

____ Tachycardia

____ Recurrent Lung Infection/Bronchitis

____ Ulcers/Gastritis

____ Heart Attacks/Angina

____ Asthma/Wheezing

____ Diabetes

____ Mid Back Pain

____ Shortness Of Breath

____ Hypoglycemia/Hyperglycemia

LUMBAR SPINE (LOW BACK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Pain in hips/legs/feet

____ Weakness/injuries in hips/knees/ankles

____ Low back pain

____ Numbness/tingling in legs/feet

____ Recurrent bladder infections

____ Coldness in legs/feet

____ Frequent/difficulty urinating

____ Muscle cramps in legs/feet

____ Sexual dysfunction

____ Constipation/Diarrhea

____ Menstrual irregularities/cramping (females)

OTHER

Please list any medications (include name, dose, for what condition, and how long you've been taking it): _____

Please list any surgeries (include type of surgery and date it was performed): _____

Family Health History

Have any of your family members ever been diagnosed with the following (*please indicate "Y" for You, and "O" for Other than you, or both if applicable*):

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Neurological Problems	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Metal Implants	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Gall Bladder
<input type="checkbox"/> Broken bones/fractures	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Hernia
<input type="checkbox"/> Pneumonia/Bronchitis	<input type="checkbox"/> Polio	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Anemia
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Chicken Pox/Shingles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Measles
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Blood Sugar Problems	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Eczema/Psoriasis	<input type="checkbox"/> Lumbago

Other: _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ____/____/____

Patient's Signature _____ Date ____/____/____

Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my spine, or the spine of the charge I represent, through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature _____ Date __/_____/____

Patient's Name Printed _____

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature _____ Date ____/____/____

In Case of Emergency

Name _____ Relationship _____

Work Phone () _____

Home Phone () _____

Cell Phone () _____

Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

ITEMIZED RECEIPTS, aka. "SUPERBILLS"

Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. This office does not participate with any insurance provider or accept such an assignment. Patients are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred as a "superbill", along with the related charges that you, in turn, can submit to your own insurance company for possible reimbursement, as well as retain for your personal records.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services? Yes No

Patient's Signature _____ Date ____ / ____ / ____

Signature of Person Authorizing Care (if different from patient):

_____ Date ____ / ____ / ____

Relationship to Insured _____ Date of Birth ____ / ____ / ____

Employer _____

Primary Insurance Company _____ Policy# _____

Address Phone # () _____

Insured's Name _____ Insured's Social Security #: _____ - ____ - _____

Secondary Insurance Company _____ Policy# _____

Address Phone # () _____

Insured's Name _____ Insured's Social Security #: _____ - ____ - _____



HIPPA FORM

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to Dr. James Dustin Taylor or Batesville Spine & Health Solutions.

I consent to the use or disclosure of my protected health information by the Chiropractor for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Chiropractor. My signature below allows the Chiropractor to analyze, diagnose and treat me.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. The Chiropractor is not required to agree to the restrictions I may request. However, if the Chiropractor agrees to a restriction that I request, the restriction is binding on the Chiropractor.

I have the right to revoke this consent, in writing, at any time, except that the Chiropractor has acted in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. The protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation of the Chiropractor. This notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Patient's Printed Name

Patient's Signature

Date

Office Staff Witness

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated the care, alternatives and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an Instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in joint, reducing pain in the Joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissection have been associated with over 72 everyday activities such as sneezing, driving and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in a million to one in two million cervical adjustments. For comparison, the incident of hospital admission attributed to aspirin use from major GI events of the entire (upper & lower) GI tract was 1219 events/ per one million person/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: / /

Parent or Guardian: _____ Signature: _____ Date: / /

Witness Name: _____ Signature: _____ Date: / /

Authorization and Assignment

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make a payment to me or you based in whole or in part upon the charges made for your services.
3. In the event of any insurance company obligated to contractual agreement to make a payment to me or to you for the charges made for your services refuses to make such a payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated to, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance company proceeds, whether it be all or part of what is due, I personally owe and agree to pay you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in the State of Arkansas.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. The Authorization for Assignment will be in continual effect until revoked by both parties.

Date

Patient /Insured Signature

Date

Staff Signature (Witness)

Electronic Health Records Intake Form

In compliance with Insurance, Medicare and Cash Patient requirements for the government EHR incentive program.

First Name: _____ Last Name: _____

Email address: _____ @ _____ . _____

Preferred method of communication (Circle one) : Email / Phone / Mail

Date of birth: / / Gender: Male / Female Preferred language:

Smoking Status (circle one) : Every Day / Occasional / Former / Never Smoked

CMS REQUIRES PROVIDERS TO REPORT RACE AND ETHNICITY

Race (circle one) : American Indian or Alaska Native / Asian / African American or Black / Caucasian or White /
Native Hawaiian or Pacific Islander / Other / Decline to Answer

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Are you currently taking any medications? (Please include over the counter medications, ex. Tylenol)

Medication Name	Dosage and Frequency (ex. 5 mg 1 x day)

Do you have any medication allergies?

Medication Name	Reaction	Onset	Additional Comments

I chose to decline receipt of my clinical summary after each visit. These summaries are often blank because of the nature and frequency of chiropractic care. These can be acquired by asking the front desk for a copy.

Patient Signature: _____ Date: / /

FOR OFFICE USE ONLY:

Height:

Weight:

Blood Pressure: