McClintock Chiropractic

1159 E Laketon Ave
Muskegon, MI 49442
P: 231-726-6355
F: 231-747-8716

Confidential Patient Health Record Date:

DEMOGRAPHIC INFORMATION

Name
Address:
Email address:
Home Phone:
Social Security #
Business Employer:
Business Phone #
Insurance Company:
Name of Insured:
Insured's Address:

City:
State: _____ Zip:
Cell Phone: _____
Birth Date: _____ Age: ____ Sex: • M • F
Circle One: Married Single Divorced Widow
Business Address:
Type Of Work:
Policy #:
Insured's Date of Birth:

Whom may we thank for referring you to us: _____

Name / Relationship of Emergency Contact: Phone Number:

CURRENT HEALTH CONDITION

Reason for today's visit: • Emergency • New Injury • Old Injury • Chronic Pain

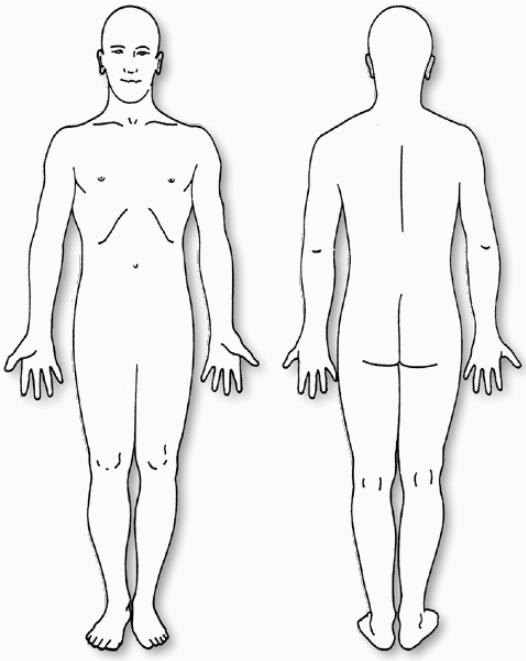
Are you in pain? • Yes • No Rate your pain with the following scale: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Describe your pain: _____and/or circle: Dull Sharp Achy Throbbing Shooting

Did your discomfort occur during: • Work • Sports/Play • Auto Accident • Routine Household Activity

When did this condition/accident occur? ____ / ____ / ____ Where did your injury occur? Please mark area(s) of pain:

Please explain what happened:



Is your condition getting worse? • Yes • No • Constant • Comes and Goes

Is your condition interfering with your: • Work • Sleep • Daily routine? If so, how?

What seems to help alleviate your pain? (i.e. ice, heat, aspirin)

What seems to make your pain worse?

Does it radiate/travel into other parts of your body? • Yes • No Where: _____

Has this or something similar happened in the past? • Yes • No

Have you seen anyone else for this condition? • Yes • No Who? _____

Type of Treatment: Results: _____

Medications you are currently taking: • Nerve Pills • Pain Killers/Muscle Relaxers • Blood Pressure Medicine • Insulin

Name:_____ Dosage: _____ Prescribed for: _____

Name:_____ Dosage: _____ Prescribed for: _____

Name:_____ Dosage: _____ Prescribed for: _____

Please attach additional pages if necessary.

Do you suffer from any condition other than that of which you are now consulting us?

PAST HEALTH HISTORY

Please Check / Describe:

Major Surgery / Operations: • Back Surgery • Broken Bones • Bone Fusions • Disc Surgery

• Other:

Major Accidents / Injuries / Falls:

Hospitalizations (Other Than Above):

LIFESTYLE

Do you take any supplements? • Yes • No If so, which one(s): _____

Do you exercise? • Yes • No Activity: _____ Amount: _____ day / wk

Do you smoke? • Yes • No Amount: _____ per day / week

Do you drink alcohol? • Yes • No Amount: _____ per day / week

Do you get eight hours of sleep every night? • Yes • No If not, why? _____

How would you classify your stress level? None 1 2 3 4 5 6 7 8 9 10 Severe

Do you have any allergies? • Yes • No If so, to what? _____

Are you pregnant? • Yes • No If so, what is your due date? _____

Date of your last physical examination: _____

Date of your last deep tissue massage: _____

Date of your last chiropractic adjustment: _____

Dr.'s Notes

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OFFICE POLICY

Welcome to our office. Our goal is to serve you with exceptionally friendly and prompt service, and to provide the best in chiropractic care for your whole family.

Chiropractic Appointments: (late and missed)

In order to provide proper chiropractic care, a personal treatment plan will be designed specifically for you.

- If an appointment must be changed, **24 hours notice is appreciated**.
- If you are going to be late please call ahead to let us know, understanding that your appointment **may** need to be rescheduled.
- No-Show appointments may be subject to a $10 missed appointment fee, which is not covered by insurance. The first no-show appointment will be forgiven and no fee will be assessed.

Initial _____

Financial Policies/Agreements:

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies.

1. Our clinic has established a single fee schedule that applies to all patients for each service provided.
2. You may be entitled to a network or contractual discount under the following circumstances:
    a. We are a participating provider in your health plan.
    b. You are covered by a State or Federal program with a mandated fee schedule.
    c. Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required on an annual basis.
3. You are eligible for a Time of Service discount of 10% off noninsurance covered services when you pay for your services (products excluded) the same day you receive them.
4. As part of our compliance plan, as of 3/1/19 our office will be unable to extend any type of discounts other than those listed above.
5. Patient statements are mailed once a month. After 60 days from the first statement mailed without a payment or making a payment arrangement your account may:
    a. Be accessed a late fee and /or be transferred to a collections service agency.
    b. Patient may be prohibited from scheduling appointments until payment arrangements are made. Payment arrangements should be made with the Office Manager or doctors.

Treatment of a Minor:

I _____ being the parent/legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

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

Date of last menstrual cycle: ____/____/____ Initial_____

Financially Responsible Party:

Print Name: _____

Relationship to the patient: _____

Address if different from patient/ where the statement is to be sent:

_____

Patient Signature_____**Date**_____

Parent/Guardian Signature_____**Date**_____

Office Use Only

Primary on account selected or created _____

Date entered _____ **Staff Initials** _____

McClintock Chiropractic HIPAA Form

Patient's Name:

Patient's SSN: Date of Birth:

Specific Authorizations-*INITIAL all that apply*

( ) I give permission to **McClintock Chiropractic** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards and any information about treatment(s). If **McClintock Chiropractic** contacts me by phone; I give them permission to leave a phone message on my answering machine or voicemail.

( ) I give **McClintock Chiropractic** permission to use and disclose my protected health information to the entities of my choosing, some of which may or may not be listed below.

Approved Entities for personal health information

Name: _____ Relationship: _____

Approved type(s) of information: ( ) Diagnosis ( ) Treatments ( ) Appointments ( ) Financial Records

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_____

Signature of Patient or Personal Representative

_____

Date

Right to Revoke HIPAA Authorization

- You have the right to revoke this authorization, in writing, at any time. Please send such requests to:
  McClintock Chiropractic
  1159 E Laketon Ave
  Muskegon, MI 49442
  Phone: 231-726-6355
  Fax: 231-747-8716
- You may refuse to sign this HIPAA authorization. If you refuse to sign this authorization it will not affect your ability to obtain treatments.
- Upon request, a copy of this authorization will be provided to you.
- I have read / received the information about the Health Insurance Portability and Accountability Act. **Initials: _____**