PATIENT INFORMATION

Date today: _____

Full Name: _____ SS#: _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____ Email: _____

Birthdate: _____ Age: _____ Sex: ☐ M ☐ F Height: ____ft____in Weight: _____

Marital Status: ☐ Married ☐ Single ☐ Other: _____ Referred to this office by: _____

Employment Status: ☐ Employed ☐ Unemployed ☐ F/T Student ☐ P/T Student ☐ Other

Employer: _____ Occupation: _____

Per HIPPA regulations:

Which phone number listed above may we leave messages regarding appointments, billing, etc. ☐ Home ☐ Cell ☐ Work

How will your bill be covered? **PATIENT BALANCES ARE DUE AT THE TIME OF SERVICE!!!!**

☐ Personal Health Ins. ☐ Medicare ☐ Medicaid ☐ Work Comp ☐ Self-Pay ☐ Auto Insurance

CURRENT HEALTH CONDITIONS

What are your major complaints? _____

Any other complaints? _____

On a scale of 0-10, 0 = No Pain & 10= Unbearable, how would you rate your pain?

0 1 2 3 4 5 6 7 8 9 10

When did you notice this condition begin? _____

How did this condition begin? _____

Does anything make the pain better? _____

Does anything make the pain worse? _____

Have you seen other doctors for this condition? Yes No If yes, who?: _____

What were the results?: _____ _____

Medications you're taking to treat THIS condition: _____

Please list all other medications: _____

Please list any allergies to any medications: _____

Females: Are you currently pregnant?: Yes No Due date: _____

PAST HEALTH HISTORY

Surgeries or operations: _____

Major accidents or falls: _____

Hospitalizations (other than noted above): _____

Have you been treated for any health conditions in the last year? Yes No

BESSMER CHIROPRACTIC, P.C.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

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 names before, for whom I am legally responsible for) by Doctor Christian Bessmer D.C., of Bessmer Chiropractic P.C.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular, and neurological aspects. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click".

I have had an opportunity to discuss with Doctor Christian Bessmer D.C., the nature and purpose of chiropractic adjustments and other procedures. I understand, and I am informed that, as in the practice of medicine, in the purpose of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon facts then known, is in my best interest.

The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. Other treatment options, which could be considered, may include the following:

1. *Over-the-counter analgesics.* The risks of these medications include irritation to the stomach, liver and kidneys, and other side effects in a significant number of cases.
2. *Medical care.* Typically, anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in significant number of cases.
3. *Hospitalization.* In conjunction with medical care, adds risk of exposure to virulent communicable disease in a significant number of cases.
4. *Surgery.* In conjunction with medical care, adds risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

I have read, or have had read to me, the above consent, and by signing below I agree to Bessmer Chiropractic P.C., procedures. I intend for this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient Name Date

_____

Signature of Patient or Legal Representative (Parent, Guardian, Attorney)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____ (patient's name) acknowledge that I can request a copy and agree to the Notice of Privacy Practices of Bessmer Chiropractic, P.C., which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Patient Consent to Use and Disclose Health Information
(Consent for Purposes of Treatment, Payment and Healthcare Operations)

I consent to Bessmer Chiropractic, P.C. ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present or future physical or mental health or condition, the provision of health care to me, or reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but that Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have the right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing at any time, except to the extent that Physician of the Practice has acted in reliance on this consent.

_____ _____
Signature of Patient or Personal Representative Date

****

Bessmer Chiropractic has my permission to release personal health information to the following people for the purpose of such things as: appointment reminders, follow-up calls, basic contact information, insurance updates and account balance statements and payments.

_____ Relationship:_____

_____ Relationship:_____

_____ Relationship:_____

The following family members may be included on the same billing statement:

_____ _____

_____ _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and healthcare benefits, to include major medical benefits to which I am entitled including Medicare, Auto Insurance, Private Health Insurance, and any other plans to Bessmer Chiropractic, P.C.

A copy or fax of this assignment is to be considered as effective and valid as the original.

I understand that I am financially responsible for **all** charges *whether paid by insurance or not*. I hereby authorize the release of **any** information necessary to secure payment.

I certify that I have read and understand the above assignment of benefits.

PRINTED NAME: _____

SIGNED_____

DATE: _____