



Central Clinic Of Chiropractic

Central Clinic of Chiropractic
11 E Calhoun St Sumter, SC
29150 (803) 757-1700

Please fill out the application entirely and legible. We need all information for insurance purposes.

Name _____ Nick Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

We need to contact you both by phone and email. Please be sure to give us the best phone number to reach you

Date of birth _____ Social Security _____

If you have Medicare, we need you to list your SSN above or provide us with the Medicare card

Your Occupation _____ Retired Yes No

Single Married Widowed Spouse Name _____

I give permission to be contacted/discuss care or appointments.

Emergency Contact Name _____

Emergency Contact Number _____

REVIEW OF SYMPTOMS

Please check all that apply

- | | | | |
|----------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Arthritis in Hands |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Hand Pain | <input type="checkbox"/> Bulging Disc | <input type="checkbox"/> Arthritis in Feet |
| <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Spinal Stenosis | <input type="checkbox"/> Plantar Fasciitis |
| <input type="checkbox"/> Jaw Pain (TMJ) | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Degenerative Disc | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Foot Numbness | <input type="checkbox"/> Vascular Problems | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Hand Numbness | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Morton's Neuroma | <input type="checkbox"/> Joint Replacment |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Cancer | <input type="checkbox"/> Foot Surgery |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Poor Wound Healing |
| <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Implanted Cord /
Bladder Stimulator | <input type="checkbox"/> Excessive Thirst
or Urination |
| <input type="checkbox"/> Gastrointestinal Disorder | | | |



PRESENT HEALTH CONDITION

01 Please list your health concerns in order of priority:

02 Is there a certain time of day any of these problems are better or worse?

03 Is your balance/walking ability affected? If yes, please describe:

04 List approximately how long you have noticed these problems in your life:

05 Circle the things you have used for these problems:

Gabapentin Aleve Heat Injections Acupuncture Tylenol Ice Creams
Ibuprofen Physical Therapy Chiropractic Opioid/Pain Prescription Massage Therapy Over-the-counter pain medication

06 What do you think is causing your problem?

07 Name all of doctors you have seen for these problems and treatment you received:



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08 Have your symptoms: Improved Worsened Stayed the same

List anything that makes your condition worse _____

List anything that makes your condition better _____

09 How would you describe the symptoms? Please check ALL that apply:

- | | | |
|----------------------------------------|---------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Aching Pain | <input type="checkbox"/> Tingling/Electric Shocks | <input type="checkbox"/> Dead Feeling |
| <input type="checkbox"/> Stabbing Pain | <input type="checkbox"/> Pins & Needles Pain | <input type="checkbox"/> Cold Hands/Feet |
| <input type="checkbox"/> Sharp Pain | <input type="checkbox"/> Heavy Feeling | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Tiredness | <input type="checkbox"/> Hot Sensation | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Throbbing Pain | <input type="checkbox"/> Burning |

10 Is this condition interfering with any of the following?

- | | | |
|--------------------------------------------------|----------------------------------|-------------------------------------------|
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Work | <input type="checkbox"/> Daily Activities |
| <input type="checkbox"/> Recreational Activities | <input type="checkbox"/> Walking | <input type="checkbox"/> Standing |

SOCIAL HISTORY

Do you smoke? Yes No If yes, how many cigarettes daily? _____

Do you drink? Yes No If yes, how many drinks per week? _____

Do you exercise? Yes No If yes, please describe type and how often? _____

CURRENT PAIN LEVELS

Please indicate your daily level of pain.

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN



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PREVIOUS HEALTH CONDITION

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name _____ Signature _____

Please give name, address, and office phone number of your primary care physician.

Name _____ Phone _____ Address _____

When were you last seen there? _____

May we send them updates on your treatment/condition? Yes No

List ALL allergies/sensitivities to medication, food, and other items here:

Items you react to:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

List the prescription drugs you are currently taking (or you may attach a list):

Name	Dose (mg or IU)	Time Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any past surgeries, date, and relevant details:

Surgery	Date	Notes/Details
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



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Name _____ Date _____

Please take several minutes to answer these questions so we can help you better.

Please check all that apply

01 How have you take care of your health in the past?

- | | |
|--------------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Nutrition/Diet |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Holistic Care |
| <input type="checkbox"/> Routine Medical | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Chiropractic |
| <input type="checkbox"/> Others (please specify) _____ | |

02 How did the previous methos(s) work out for you?

- | | |
|------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Bad Results | <input type="checkbox"/> Did Not Get Worse |
| <input type="checkbox"/> Some Results | <input type="checkbox"/> Did Not Work Very Long |
| <input type="checkbox"/> Good Results | <input type="checkbox"/> Still Trying |
| <input type="checkbox"/> Nothing Changed | <input type="checkbox"/> Confused |

03 How have others been affected by your health condition?

- | | |
|------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> No One Is Affected | <input type="checkbox"/> They Tell Me To Do Something |
| <input type="checkbox"/> Haven't Noticed Any Problem | <input type="checkbox"/> People Avoid Me |



04 What are you afraid this might be (or beginning) to affect (or will affect)?

- | | |
|-----------------------------------------|-----------------------------------|
| <input type="checkbox"/> Job | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Kids | <input type="checkbox"/> Time |
| <input type="checkbox"/> Future Ability | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Freedom |
| <input type="checkbox"/> Self-Esteem | |

05 Are there health conditions you are afraid this might turn into?

- | | |
|-------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Family Health Problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Need Surgery |
| <input type="checkbox"/> Arthritis | |

06 How has your health condition affected your job, relationships, finances, family, or other activities?
Please give examples:

07 What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:

1. _____
2. _____
3. _____



08 What are you most concerned with regarding your problem?

09 Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

10 What would be different/better without this problem? Please be specific.

11 What do you desire most to get from working with us?



Office Financial Policy

Our office is considered a private pay office, meaning we do not bill 3rd party insurance.

1. This office will make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed after your report of findings.
2. **Cancellation Policy:** Please call at least 24 hours before your scheduled appointment if you need to reschedule. This allows for the change to be and for the now available time to open for another patient. For all “no call, no shows”, there may be a \$50 fee charged to your account. Certain exceptions may apply.
3. If the patient discharges self from care, the balance is due in full for services that have been rendered within a month of stopping care. If payment arrangements are set up, the auto debits may run so that services rendered are covered. If there is an opposite imbalance from services to payments, a credit or refund may be issued.

Medicare/Insurance

4. If you have Traditional Medicare, as a courtesy to you, all claims will be submitted on your behalf so if Medicare chooses to reimburse you, they will directly.
5. Medicare policy, or a private insurance policy, we will give you all the necessary paperwork for you to submit your own claims to your insurance (itemized bill).

I understand and agree that health / accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Central Clinic of Chiropractic can provide an itemized bill upon request (within the first month of care. We will not provide itemized bills for past months of services) to assist me in making collections from my insurance company based on my policy if I choose to do so. I further understand the financial policy and accept the financial fee of \$50 that may be charged to my account in a no call no show circumstance for my appointment that I scheduled. I clearly understand and agree that I am personally responsible for payment due for services rendered. Any payments made to Central Clinic of Chiropractic including pre-paid services, package purchases, or account credits must be used within 12 months of the original payment date. If credit on the account is not used within 12 months it will be considered non-refundable and no longer eligible for cash or card reimbursement. This policy applies to all forms of payment, including but not limited to: prepaid adjustment packages, gift certificates, overpayments, personal or third-party payments. We encourage patients to maintain regular care and communication with our office to avoid forfeiture of unused credit.

Signature _____

Date _____



HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical health or mental health or condition, and related health care services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you, pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third-party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain prior approval for the hospital admission.

Healthcare Operations

We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI as necessary to contact you to remind you of your appointment.



We may use or disclose your PHI in the following situation without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroner, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures, Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization, or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights. Following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI.

Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction on your PHI.

This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

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You may have the right to have your physician amend your PHI.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.



You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this Notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this Notice.

Complaints.

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This Notice was published and becomes effective on/before April 1, 2019.

We are required by law to maintain the privacy of, and provide individuals with, this Notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signing below is only acknowledgment that you have received this Notice of our Privacy Practices.

X _____