Confidential Patient Health Record

Date: ID No.

PERSONAL HISTORY

Name: _____ Address: _____

2nd Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____ Cell: _____ Birth Date: _____ Age: _____ Sex: M F

Social Security #: _____ Drivers License #: _____

E-Mail: _____ Circle One: Single Widowed Divorced Married

Business Employer: _____ Type of Work: _____

Business Phone: _____ Name of Spouse: _____

Spouse's Social Security #: _____ Spouse's Cell: _____

Spouse's Employer: _____ Business Phone: _____

Type of Work: _____ Names and ages of Children: _____

Referred to this office by: _____ _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who is responsible for your bill: you and Spouse Worker's Comp Auto Insurance Medicare Medicaid

Personal Health Insurance (Name) _____ Health Card # _____

CURRENT HEALTH CONDITION

Purpose of this appointment: _____

Other doctors seen for this condition? Yes No Who? _____

Type of treatment: _____ Results: _____

When did this condition begin? _____ Has this condition occurred before? Yes No

Is condition: Job related Auto Accident Fall Home Injury Other: _____

Date of accident: _____ Time of accident: _____

Have you filed a report of your accident to your employer? o Yes o

Drugs you now take: oNerve Pills o Pain killers/muscle relaxers oBlood pressure medicine oInsulin oHormones

oOther: _____ Do you wear a shoe lift? o Yes o No

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

_____

PAST HEALTH HISTORY

Please Check and Describe:

Surgeries: oAppendectomy oTonsillectomy oGall Bladder oHernia oBack Surgery oBroken Bones oHyster/Glands

o Other: _____

Major Accidents or Falls and dates: _____

_____

Hospitalization (Other than above): _____

Previous Chiropractic Care oNone o Doctor's name and approximately date of last visit: _____

THANK YOU FOR CHOOSING COASTAL CHIROPRACTIC CLINIC AS YOUR HEALTH CARE PROVIDER. WE ARE COMMITTED TO PROVIDING YOU THE VERY BEST CARE AVAILABLE. PLEASE READTHE FOLLOWING AGREEMENTS AND SIGN THAT YOU UNDERSTAND AND AGREE. IF YOU HAVE ANY QUESTIONS WE'LL BE GLAD TO HELP.

1. All first visit charges are payable when services are rendered.
2. The fee paid for treatment x-rays is for professional analysis only. The film itself is the property of this office. Copies may be made if necessary. There is a fee for these copies.
3. I understand that cash and prepayment plans will save me and any of my insurance companies money.

Please refer to our policy handout for other points.

4. I, HEREBY REQUEST AND CONSENT TO THE PERFORMANCE of chiropractic adjustments and other chiropractic procedures; including various modes of physiological therapeutics and diagnostic x-rays on myself or the dependent patient named _____ (for whom I am legally responsible), by the doctors and staff under the management of the professional corporation doing business as Coastal Chiropractic Clinic. I understand that there are some risks to treatment including, but not limited to, fractures, disc injury, stroke, dislocations and strains. I wish to rely on the doctor to exercise judgment during the course of procedures that the doctor feels at the time, based upon the facts then known, is in my best interest.

5. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Coastal Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collections from the insurance company and I authorize the release of my medical records as needed to submit claims and that any amount authorized to be paid directly to Coastal Chiropractic Clinic will be credited to my account upon receipt. **However**, I clearly understand and agree that I am personally responsible for payment.

6. I hereby authorize payment from insurance carrier for services rendered to me. In the event I receive payment from my insurance carrier, where benefits have been assigned to the Coastal Chiropractic Clinic, I agree to endorse any payment I receive over to Coastal Chiropractic Clinic from which those fees are payable. I further agree that should it become necessary that an Attorney or Collection Agent be employed to collect the amount between myself and the Clinic, that I will pay the reasonable cost of services incurred.

ALL CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH A MEMBER OF THE CLINIC STAFF.

There will be a $25.00 charge on all returned checks.

There will be a 1.5% monthly late fee charged to accounts over 60 days with no payment from the patient.
Any refunds due will be paid at the end of the month that the overpayment occurred.

Any patient being treated for a PERSONAL INJURY and having no personal MED PAY Insurance coverage will be required to pay for their services, unless other arrangements are made with the Clinic's INSURANCE COORDINATOR.

ALL WORKER'S COMPENSATION INJURIES must have an authorization from their employer or charges will be the patient's responsibility alone until the authorization is returned. Any exceptions must be authorized by the Clinic's INSURANCE COORDINATOR. Group Insurance DOES NOT cover injuries that occur on-the-job.

7. I have read the above consent, and I intend for this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment.

_____ _____
Patient's Signature Date

_____ _____
Guardian's Signature Authorizing Care for Minor Date

In case of emergency, please notify: _____
Name of nearest relative not living with you

_____ _____
Relationship Address

(________)____

Phone