Carolina West Clinic
Chiropractic and Functional Medicine

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

Name____ **Nickname**_________________________

Address____

City____**State**______**Zip**______________________

Home Phone____________________ **Mobile Phone**____________________ **Email**______________________

Date of Birth____________________________ **Social Security**____________________________

Spouse's Name__________________________ **Phone**__________________________________

Your Occupation____ **Retired? Yes / No**

REVIEW OF SYMPTOMS

Please Circle ALL that apply

Foot Pain	Diabetes	Spinal Stenosis	Cancer	Pinched Nerve
Hand Pain	High Cholesterol	Degenerative Disc	Chemotherapy	Poor Circulation
Low Back Pain	High Blood Pressure	Vascular Problems	Arthritis in Hands	Joint Replacement
Neck Pain	Pacemaker/Defibrillator	Leg Pain	Arthritis in Feet	Foot Surgery
Foot Numbness	Herniated Disc	Plantar Fasciitis	Poor Wound Healing	Sciatica
Hand Numbness	Bulging Disc	Morton's Neuroma	Excessive Thirst/Urination	Implanted Cord/Bladder Stimulator

PRESENT HEALTH CONDITION

In order of importance, list the health problems you are most interested in getting corrected:

1.____

2.____

3.____

4.____

List approximately how long you have noticed these problems:

1.____

2.____

3.____

4.____

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

____

____

____

____

Circle the things you have used for these problems:

Gabapentin	***Neurontin***	***Lyrica***	***Cymbalta***
Physical Therapy	***Pain Medications***		***Aleve***
Tylenol	***Ibuprofen***	***Motrin***	***Chiropractic***
Massage Therapy	***Injections***		***Creams***

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

____

____

____

____

What do you think is causing your problem?

____

____

____

____

Have your symptoms: ☐ Improved ☐ Worsened ☐ Stayed the same

List anything that makes your condition worse ____

____

List anything that makes your condition better____

____

How would you describe the symptoms? Please circle ALL that apply

Aching Pain	Numbness	Hot Sensation	Cramping
Stabbing Pain	Tingling	Throbbing Pain	Swelling
Sharp Pain	Pins & Needles Pain	Dead Feeling	Burning
Tiredness	Heavy Feeling	Cold Hands/Feet	Electric Shocks

Is this condition interfering with any of the following?

Sleep | Work | Daily Activities | Recreational Activities | Walking | Standing

SOCIAL HISTORY

Do you smoke?	**Yes**	**No**	**If yes, how many cigarettes daily?**______________________
Do you vape?	**Yes**	**No**	**If yes, how much daily?**________________________________
Do you drink alcohol?	**Yes**	**No**	**If yes, how many drinks per week?**_____________________
Do you exercise?	**Yes**	**No**	**If yes, please describe they and how often?** ____________________________

CURRENT PAIN LEVELS

How would you rate your pain in the last week?

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

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

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

PREVIOUS HEALTH HISTORY

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 copied 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:

Item you react to:	Reaction:
____	____
____	____
____	____
____	____

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

Name	*Dose (mg or IU)*	*Times Daily*
_____________________________________	_________________	____________________
_____________________________________	_________________	____________________
_____________________________________	_________________	____________________
_____________________________________	_________________	____________________

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

Name	*Dose (mg or IU)*	*Times Daily*
_____________________________________	_________________	____________________
_____________________________________	_________________	____________________
_____________________________________	_________________	____________________
_____________________________________	_________________	____________________

Acknowledgment – Notice of Privacy Practices

I hereby acknowledge receipt of **Notice of Privacy Practices**. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information. I understand that Carolina West Clinic of Chiropractic has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided or made available to me.

Signature ____Date _____________

Acknowledgment – Consent for Use or Disclosure of Protected Health Information for Payment, Treatment and Healthcare Operations.

By signing below, I have received, read, and understand the **Consent for Use or Disclosure of Protected Health Information for Payment, Treatment and Healthcare Operations** form and acknowledge receipt of the Notice of Privacy Practices. My signature represents agreement with these practices.

Signature ____Date________________

I authorize Carolina West Clinic Chiropractic and Functional Medicine to release any and all information (including verbal information, copies of x-rays and medical paperwork, and/or financial information) concerning to the following individuals:

____

Name (please print) Relationship Name (please print) Relationship

OR

_____ I DO NOT authorize Carolina West Clinic of Chiropractic to release any information concerning my care to any individual.

Acknowledgment – Chiropractic Informed Consent.

By signing below, I have received, read, and understand the **Chiropractic Informed Consent** form entirely. My signature represents consent for treatment with chiropractic care.

Signature ____Date________________

CHIROPRACTIC INFORMED CONSENT

You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

CHIROPRACTIC
Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. Chiropractic healthcare seeks to restore health through a natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its inherent healing powers.

ANALYSIS
A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation. A subluxation occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.
DIAGNOSIS
The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. Due to the complexities of nature, no doctor can promise you specific results. This depends on your body's healing mechanism. If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.
BENEFITS AND RISKS
Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be a highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.
All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements above. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Consent for Use or Disclosure of Protected Health Information for Payment, Treatment and Healthcare Operations

By signing , you hereby consent for Carolina West Clinic Chiropractic and Functional Medicine to use or disclose information about you (or person for whom you have the authority to sign) that is protected under federal law, for the sole purpose of treatment, payment and health care operations to: INSURANCE COMPANY, ATTORNEY, OR ADJUSTER for the purpose of determining eligibility, available benefits and obtaining payment for services provided.

AUTHORIZATION TO RELEASE MEDICAL/FINANCIAL INFORMATION (VERBAL AND COPIES)
In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, in order for the doctors or staff of Carolina West Clinic of Chiropractic to give copies of and/or discuss your condition/exam/procedures/x-rays or finances with members of your family or other individuals, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

I authorize Carolina West Clinic Chiropractic and Functional Medicine to leave a message at the numbers listed in my patient information regarding appointment times.

I authorize Carolina West Clinic Chiropractic and Functional Medicine to send correspondence to me at the address listed in my patient information.

I understand that I need not supply address or phone numbers provided I do not wish to be contacted. In such case, I agree to pay for all charges incurred at the time of service.

I hereby give my permission to publish my name and picture(s) in whole or part in any of the publications of Carolina West Clinic Chiropractic and Functional Medicine.

I understand that I can refuse my picture to be on file with the office if I do not wish for my picture to be published by Carolina West Clinic Chiropractic and Functional Medicine.

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

You have the right to revoke this authorization in writing at any time. However, your written request is not effective to the extent that we have already provided services or taken actions based on your prior authorization. Revocation is not effective until it is received by the privacy official. If I refuse to sign this authorization, Carolina West Clinic of Chiropractic will not refuse treatment, however, it will not be possible for Carolina West Clinic of Chiropractic to file third party billing on my behalf, and I will be responsible for payment at the time services are provided to me and scheduling my own appointments. Any collection activity as permitted by law is not waived by refusal to sign the authorization.

OFFICE POLICIES

MISSED APPOINTMENTS:

We strive to deliver the highest care possible to our patients. To meet this goal, we reserve appointment times for each patient and try to keep our patients from waiting. An appointment is a mutual agreement that we will be here to serve you and that you will be present for the appointment. It is important to be present for your scheduled appointments so that the doctor can treat you according to his/her prescribed plan. If you are unable to keep your appointment for any reason, we request that you call us immediately to reschedule. **Please be aware that there may be a $25 missed appointment fee charged to your account for any scheduled appointments missed or not cancelled within 24 hours prior to the appointment time.**

2. We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait until the next available appointment.

3. Should more than a 12-month period elapse between office visits, a re-evaluation is necessary prior to reinstating treatment.

FINANCIAL:

4. Payment is due at the time of service unless a prior arrangement has been made. Patients with an outstanding must make arrangements for payment prior to scheduling appointments. Any balance over 180 days will be forwarded to a collection agency. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payable in full immediately, regardless of any previous arrangements or discounts.

INSURANCE:

5. Many insurance companies cover our care; however, we do not accept assignment for Major Medical, Medicare, or Personal Injury. Please give us your insurance cards and we will electronically file your claims to your primary insurance company.

6. Your first visit will not be submitted to insurance if you are using a promotional gift to assist in the cost.

7. We do not submit claims for secondary insurance companies. We will provide you with a super bill that lists all the codes, charges, and numbers required for billing that you can send to your secondary insurance once the primary has paid you.

I have read and understand the Office Policies. I agree to assign insurance benefits to Carolina West Clinic Chiropractic and Functional Medicine whenever necessary (Medicare). I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

If you have any questions concerning this or any other matter, please speak with the receptionist prior to seeing the doctor.

NOTICE OF OUR PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed, as required the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

PLEASE REVIEW THIS NOTICE CAREFULLY

We are required by law to abide by the terms of this Notice and to provide you with a copy of this notice. We may change the terms of our notice at any time. The new notice will be effective for all protected information that we maintain at that time.

The following categories describe the different ways in which we may use and disclose your information:

1. **Treatment:** We will use and disclose your information to provide, coordinate or manage your chiropractic care and any related services. Any of the people who work for our practice – including, but not limited to, our staff and any provider we refer you to – may use or disclose your information to treat you, or to assist others in your treatment.

2. **Payment.** Our practice may use and disclose your information to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your information to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your information to bill you directly for services and items.

3. **Health Care Operations.** Our practice may use and disclose your information to operate our business. These activities include, but are not limited to: quality assessment activities, employee review activities, training of staff/students, substitute or observing chiropractors and marketing.

   In addition, we may also call you by name in the waiting or adjusting room. Your name or picture may be used in our office on bulletin boards, in newsletters, or on our website or social marketing sites unless you have specifically requested for us not to do so.

4. **Appointment Reminders.** Our practice may use and disclose your information to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment. We may mail appointment reminders, announcements or greeting cards to your home.

5. **Treatment Options.** Our practice may use and disclose your information to inform you of potential treatment options or alternatives.

6. **Release of Information to Family/Friends.** Our practice may release your information to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.

7. **Disclosures Required by Law.** Our practice will use and disclose your information when we are required to do so by federal, state, or local law. We may disclose your information to public health authorities authorized by law to collect information for the purpose of public health risks, lawsuits, etc.