**Patient Information**

Patient Name: \_\_\_\_ Date: \_\_\_\_\_\_

Age: Date of Birth: Male / Female Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I prefer to receive calls at (circle) Home / Work / Cell Is it ok to leave a message at this number? Yes / No

I am (circle) Under Age 18 /Single / Married / Divorced / Widowed / Separated

Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary care physician: Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date last seen: May we update them on your condition? Yes / No

Have you seen a chiropractor before? Yes / No Name of Chiropractor & Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Last Seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How were you referred to us? \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please have your insurance card and driver’s license ready do they can be copied for the clinic’s records.**

**Consent for Treatment**

***Assignment & Release*** *- By signing below, I authorize Hartter Chiropractic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Hartter Chiropractic and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

*By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.*

**Signature of patient (or legal guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health Questionnaire**

Do you exercise? Yes / No Hours per week? \_\_\_\_ What activity(s)? \_\_\_\_\_\_\_\_

Are you dieting? Yes / No Since: \_\_\_\_\_ Do you smoke? Yes / No How many cigarettes per day? \_\_\_\_ Since when? \_\_\_\_\_\_

Do you drink alcoholic beverages? Yes / No How many drinks per week? \_\_\_\_\_\_\_\_\_

Do you wear (circle) ? Heal Lifts / Arch Supports / Prescription Orthotics

Women: Are you pregnant or nursing? Yes / No If pregnant, How many weeks? \_ Date of last menstrual period: \_\_\_\_\_\_\_\_\_\_

**Please list all prescriptions/non-prescriptions, as well as other supplements you take and the associated condition:**

 Medication & Dosage Condition

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please list any surgeries or hospitalizations you have had complete with the month and year for each:**

 Date Surgery or Hospitalization

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please list any allergies that you have and the associated reaction:**

Allergy Reaction

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medical History**

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the individual’s

relationship to you):

 Disease Relationship

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**For the conditions below, please indicate if you have had the condition in the past or presently have the condition.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Past** | **Present** | **Condition** | **Past** | **Present** | **Condition** | **Past** | **Present** | **Condition** |
|  |  | Abdominal Pain |  |  | Elbow/upper arm pain |  |  | Liver/Gall Bladder Disorder |
|  |  | Abnormal Weight gain/loss  |  |  | Epilepsy  |  |  | Loss of Bladder Control |
|  |  | Allergies Headache |  |  | Excessive thirst  |  |  | Low back pain |
|  |  | Angina  |  |  | Frequent Urination  |  |  | Mid back pain |
|  |  | Ankle/foot pain  |  |  | General Fatigue |  |  | Neck pain |
|  |  | Arthritis |  |  | Hand pain  |  |  | Painful Urination |
|  |  | Asthma  |  |  | Heart attack  |  |  | Prostate Problems |
|  |  | Bladder Infection  |  |  | Hepatitis |  |  | Shoulder pain |
|  |  | Birth Control Pills |  |  | High blood pressure |  |  | Smoking/tobacco Use |
|  |  | Cancer  |  |  | Hip/upper leg pain |  |  | Stroke |
|  |  | Chest Pains  |  |  | HIV/AIDS |  |  | Systematic Lupus |
|  |  | Chronic Sinusitis  |  |  | Hormone Therapy |  |  | Thoracic Outlet Syndrome |
|  |  | Depression |  |  | Jaw pain |  |  | Tumor |
|  |  | Dermatitis/Eczema  |  |  | Joint swelling/stiffness |  |  | Ulcer |
|  |  | Dizziness  |  |  | Kidney Stones |  |  | Upper back pain |
|  |  | Drug/Alcohol Use   |  |  | Knee/lower leg pain |  |  | Wrist pain |

**Description of Condition**

Mark any area(s) of discomfort with the following key

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other

On a scale of one to ten how intense are your symptoms? Not intense 1 2 3 4 5 6 7 8 9 10 Unbearable

Describe the reason(s) for your doctor visit today:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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When did your symptoms start? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** How did your symptoms begin? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How often do you experience symptoms? (Circle one)Constantly Frequently Occasionally Intermittently

Describe your symptoms? (circle all that apply)Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities? \_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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Have you experienced these symptoms in the past? Yes / No When did you last experience these symptoms? \_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Dr. Scott Hartter, DC (referred to as “Doctor”) to use and disclose protected

health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Doctor’s Notice

of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Doctor reserves

the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained

by forwarding a written request to the Doctor’s Privacy Officer at 3543 Winton Place, Rochester, NY 14623.

With this consent, the Doctor may call my home or any other alternative location and leave a

message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as

appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results

among others.

With this consent, the Doctor may mail to my home or other alternative location any items that assist the

practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are mailed

personal and confidential.

I have the right to request that the Doctor restricts Hartter Chiropractic uses or discloses my PHI to carry

out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to the Doctor’s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later, revoke it, the Doctor may decline to provide treatment to me.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Printed Name Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient or Legal Guardian**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of Legal Guardian (if applicable)**

**Financial Policy**

**Insurance Coverage**

Welcome to Hartter Chiropractic.Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deductible of $100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your $100 at the beginning of the year. Our clinic will call your insurer to verify your benefits; however, we are not responsible for your insurer’s final payment and benefit determinations.

**Payments**

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

**Private Pay: (please initial)**

**A** As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

**B** I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

**Health Insurance: (please initial)**

**C** I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

\_\_\_\_\_\_\_\_ We value our time and the time of our patients. A missed appointment with no prior

(initial) call will result in a charge of $20, due at the time of your next visit.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Printed Name Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient or Legal Guardian**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of Legal Guardian (if applicable)**