Hastings Chiropractic Wellness & Center

Office: 830-755-9109
Fax: 830-755-9114
E-mail: southpawchiro@gvtc.com
www.BoerneChiropractors.com

Welcome

Thank you for choosing our practice for your needs. Please complete this form in ink.
We will be happy to help you with any questions or concerns, so please do not hesitate to ask for assistance.

(Please Print)

PATIENT INFORMATION:

❑ Mr. ❑ Mrs.
❑ Miss ❑ Ms.

Patient's Name: _____ Date: _____ SS#: _____

Street Address: _____ City: _____ State: ____ Zip: _____

❑ Male
❑ Female

Home Phone: _____ Work Phone: _____ Cell phone: _____

E-mail: _____ DL#: _____ DOB: _____ Age: ___

Would you like to sign up to receive: (Please initial to indicate your permission for us to contact you.)

Initials

_____ E-mail ❑ Appointment reminders ❑ Coupons ❑ Newsletters ❑ Birthday cards ❑ Thank you's

_____ Text ❑ Appointment reminders ❑ Specials

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No preference

Your employer (school): _____ Occupation/Type of Work: _____

Work address: _____ City: _____ State: ____ Zip: _____

Name of local friend or relative: _____ Relationship to patient: _____ Phone: _____

How did you choose us? (please check one box): ❑ referral from Dr. _____ ❑ Family _____

❑ Close to home/work ❑ Yellow Pages ❑ Website _____ ❑ Friend _____

Other family members seen here: _____

FINANCIAL RESPONSIBILITY:

Person responsible for bill (if different): _____

Address if different from patient: _____ Phone: _____

DOB: _____ Relationship to patient: _____ Work Phone: _____

INSURANCE INFORMATION: (PLEASE GIVE YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST.)

Is this patient covered by insurance? ❑ Yes ❑ No Primary Insurance : _____

Subscriber's name: _____ Subscriber's SS#: _____DOB: _____

Group #: _____ Policy #: _____ Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child

Name of secondary insurance (if applicable): _____ Group #: _____ Policy #: _____

Subscriber's name: _____ Subscriber's SS#: _____ DOB: _____

AUTO OR WORK INJURY?:

Date of Accident: _____ Insurance Co: _____ Adjustor: _____ Claim #: _____

Brief description of the accident: _____

_____

The above information is complete and true to the best of my knowledge.

Patient/Guardian signature: _____ *Date:* _____

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SYMPTOMS:

Reason for visit: _____ **When did you first notice symptoms?** _____

Where, specifically, is the problem located? _____

Which activities are difficult to perform? _____

❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Other _____

Type of pain:

❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting

❑ Burning ❑ Tingling ❑ Cramping ❑ Stiffness ❑ Swelling ❑ Other _____

Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain):

1 2 3 4 5 6 7 8 9 10

What treatment have you already received for your condition?

❑ Medication ❑ Physical Therapy ❑ Surgery ❑ Other _____

Name and address of other doctors who have treated you for your condition: _____

_____

HEALTH HISTORY:

❑ AIDS/HIV
❑ Alcoholism
❑ Allergy
❑ Anemia
❑ Anorexia
❑ Appendicitis
❑ Arthritis
❑ Asthma
❑ Bleeding Disorder
❑ Breast Lump
❑ Bronchitis
❑ Bulimia
❑ Cancer
❑ Cataracts
❑ Chemical Dependency
❑ Chicken Pox
❑ Depression
❑ Diabetes
❑ Emphysema
❑ Epilepsy
❑ Fractures
❑ Glaucoma
❑ Goiter
❑ Gonorrhea
❑ Gout
❑ Heart Disease
❑ Hepatitis
❑ Hernia
❑ Herniated Disk
❑ Herpes
❑ High Cholesterol
❑ Kidney Disease
❑ Liver Disease
❑ Measles
❑ Migraine Headaches
❑ Miscarriage
❑ Mononucleosis
❑ Multiple Scleroses
❑ Mumps
❑ Osteoporosis
❑ Pacemaker
❑ Parkinson's Disease
❑ Pinched Nerve
❑ Pneumonia
❑ Polio
❑ Prostate Problems
❑ Prosthesis
❑ Psychiatric Care
❑ Rheumatoid Arthritis
❑ Scarlet Fever
❑ Stroke
❑ Suicide Attempt
❑ Thyroid Problems
❑ Tonsillitis
❑ Tuberculosis
❑ Tumors, Growths
❑ Typhoid Fever
❑ Ulcers
❑ Vaginal Disease
❑ Whooping Cough
❑ Hypertension
❑ _____
❑ _____
❑ _____

DAILY HABITS:

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work) _____

_____

What vitamins do you currently take? _____

What other nutritional supplements do you take? _____

Do you smoke? ❑ No ❑ Yes **How much per day?** _____

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume daily? _____

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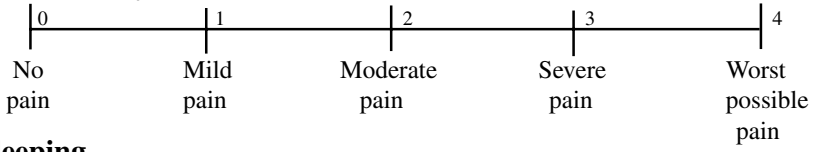
Functional Rating Index

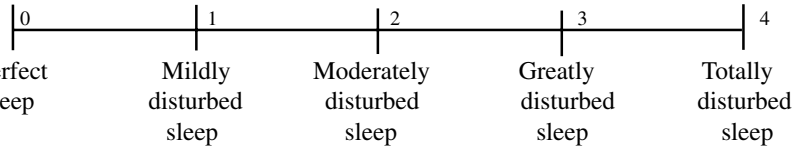
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

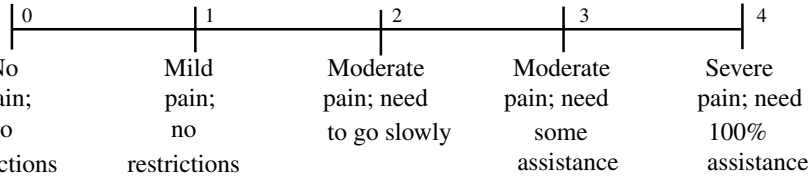
1. Pain Intensity



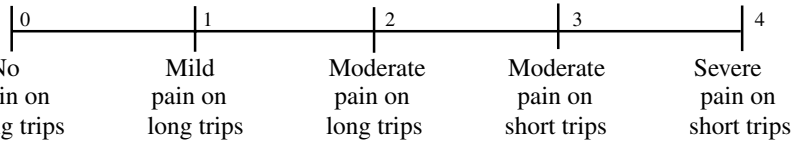
2. Sleeping



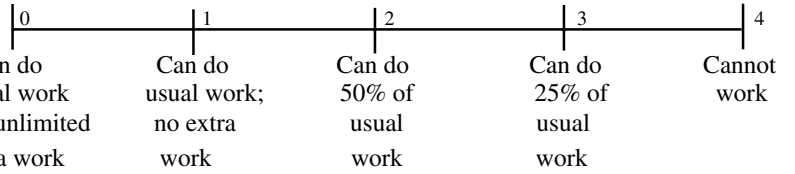
3. Personal Care (washing, dressing, etc.)



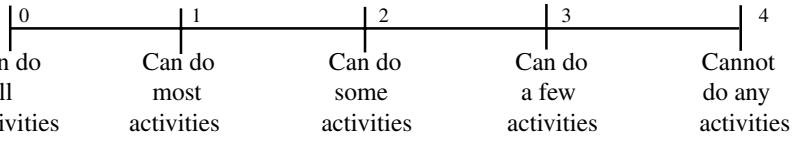
4. Travel (driving, etc.)



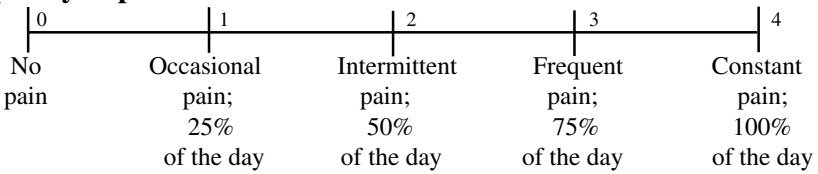
5. Work



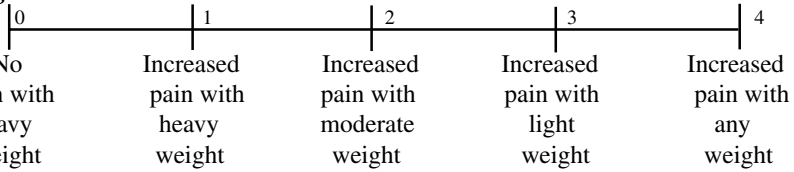
6. Recreation



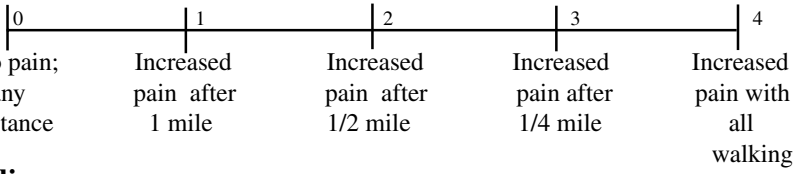
7. Frequency of pain



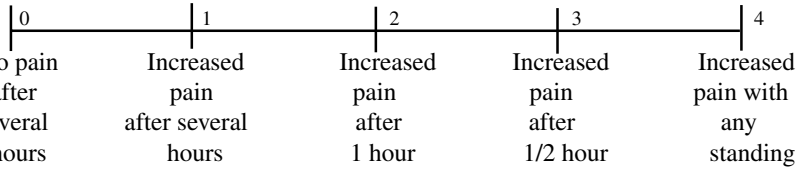
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

Hastings Chiropractic & Wellness Center

Consent to Treatment

I certify I have read and I understand the information provided by Hastings Chiropractic & Wellness Center (HCWC). I completed the requested medical information to the best of my knowledge, and I have responded accurately to the questions. I understand if I withhold information or provide inaccurate information it would not be in my best interest to improve my condition or health. I understand it is in my best interest for the Doctor to be aware of my conditions and health history to receive accurate and effective health and medical care. I hereby authorize Dr. David Hastings and the Staff at Hastings Chiropractic & Wellness Center to treat my condition, or my child's condition, as he deems appropriate through the use of manipulation, mobilization throughout the spine, and therapeutic procedures.

_____ _____

Patient Signature Date

_____

Relationship to Patient

X-RAY Agreement

It is understood Hastings Chiropractic & Wellness Center will be reimbursed for radiographs completed, and these films will be used for examination and services provided. These x-ray films will remain the property of this office where they may be viewed at any time for the purpose of treatment. If I need these x-rays for any medical reason, I understand I may check out the films; however, they are under my responsibility once signed out of this office.

_____ _____

Patient Signature Date

Hastings Chiropractic & Wellness Center

Insurance and Payment Contract

Our office will accept your insurance on assignment. It must be fully understood that your insurance policy is a contract between you and your insurance company and does not imply a guarantee that our charges will be covered. Our office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. All charges incurred are your responsibility.

1. At the beginning of your treatment, or if your insurance changes, our office will make every attempt to verify your policy benefits. However, this office DOES NOT guarantee your insurance policy or payments. In addition, this office is not responsible for inaccurate information quoted by your insurance company.

2. Your insurance will be filed as a courtesy to you. We file insurance claims on a weekly basis.

3. If your policy requires a referral from your Primary Care Physician, you are responsible for obtaining that referral. We will forward any information or forms they may require to give that referral. If your policy requires pre-certification or prior authorization, we will make every effort to obtain that for you if we know in advance of that requirement.

4. You will be responsible for your deductible and /or co-payment at the time of service unless other arrangements are made.

5. In some instances, your insurance company may require additional information before they will process your claim. It is your responsibility to contact your insurance company with any requested information in a timely manner.

6. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for approximately 60 days from the date on which the claim was filed. In the event that your insurance company does not pay on a timely basis, we will bill you for payment.

7. If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

8. If the insurance company overpays in error, the refund will be to your insurance company.

I have read and understood the policy regarding insurance assignments and payment obligations. I authorize that payment be made directly to Dr. Hastings/ Hastings Chiropractic & Wellness Center for any insurance benefits or reimbursement for services rendered by the doctor, which amounts would be otherwise payable to me under any insurance or pre-paid plan. I authorize the release of any information necessary to secure this payment. I also understand that there is no guarantee that my insurance company or pre-paid health plan will cover or pay for all of my charges and I am responsible for all remaining charges.

I understand that all responsibility for payment for services provided in this office for myself and/or my dependents is mine, due at the time of services unless other arrangements have been made. If your claim is denied, cut or refused you will be expected to pay for services rendered. I agree to pay any attorney fees if this account is turned over to collection.

Patient/ Guardian/ Insured Signature: _____ Date: _____

Hastings Chiropractic & Wellness Center

ACKNOWLEDGEMENT RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I have been notified Hastings Chiropractic & Wellness Center is compliant with HIPAA regulations. The HIPAA Privacy Rule establishes national standards to protect individual medical records and personal health information. HIPPAA requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions to the uses and disclosures that may be made of such information without patient authorization.

_____ _____

Patient Signature Date

_____

Relationship to Patient

HIPAA Authorization to Release Medical Information

Due to HIPAA Regulations and our promise to provide you with the utmost privacy, this HIPAA Authorization to Release Medical Information Form is designed to allow only certain people whom you select to have access to your medical information. (example: spouse, children, family friend, medical facility)

I hereby authorize the following people to have access to my medical information:

(This includes but is not limited to: sitting in during my consultations with the physician, and calling the office to check my medical status. This authorization will hold in effect until I submit a written notice of any changes.)

Name	**Relationship**	**Authorization Date**	**Date Authorization Revoked**
1.			
2.			
3.			
4.			

_____ _____

Patient Signature Date