Henry Chiropractic Clinic Patient Registration and History

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip Code

Sex ☐ male ☐ female Age ____ Birth date _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient S.S.# _____

Occupation _____

Employer _____

Employer _____

Address _____

Employer Phone _____

Spouse's name _____

Birth date _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Your E-mail: _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____ ID#

Group # _____ Employer _____

Is patient covered by addition insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birth date _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____ Employer _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Henry Chiropractic Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____

Relationship Date

3 PHONE NUMBERS

Home _____ Work _____

Cell Phone _____ **Carrier** _____

In case of emergency, contact

Name _____ Relationship _____

Home phone _____ work phone _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

5 PATIENT CONDITION

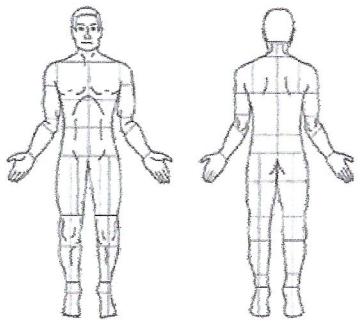
Reason for visit _____

When did your symptoms appear? _____

Dates of similar symptoms _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Please mark an "X" on the picture above where you continue to have pain, numbness, or tingling



Rate the severity of your condition on a scale of 1(mild)-10(very severe) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant, or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatments have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name and contact information for other doctor(s) who have treated your condition _____

Date of Last:					
Physical Exam	_____	Spinal X-ray	_____	Blood Test	_____
Spinal Exam	_____	Chest X-ray	_____	Urine Test	_____
Dental X-ray	_____	MRI, CT-Scan, Bone Scan	_____		

Place a mark on the "Yes" to indicate if you have had any of the following:

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

Exercise
☐ None
☐ Moderate
☐ Daily
☐ Heavy

Work Activity
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Habits
☐ Smoking — Packs/Day _____
☐ Alcohol — Drinks/Week _____
☐ Coffee/Caffeine Drinks — Cups/Day _____
☐ High Stress Level — Reason _____

Are you pregnant? ☐Yes ☐ No If **Yes**, Due Date _____

Injury/Surgeries you have had:	Description	Dates
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries:		

7

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy name:		
Pharmacy phone:		

Henry Chiropractic Clinic

8820 Goodman Road
Olive Branch, MS 38654
Office 662-890-5454
Fax 662-903-8343

OR

2620 Hwy 51 S
Hernando, MS 38632
Office 662-449-7534
Fax 662-449-7533

Patients Name _____ File # _____

Consent for Treatment, Authorization to release Medical Information and Assignment of Insurance Benefits for Clinic and Physicians

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Henry Chiropractic Clinic, to release or disclose information from my chiropractic record pertaining to my treatment, in accordance with the policies of this clinic, to insurance companies and/or medical benefits programs as needed to process my claim.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT: I certify that the information given by me in applying for payment under the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a Medicare related claim. I request that payment of authorized benefits made on my behalf. I assign the benefits payable for services rendered to the physicians or organization furnishing such services.

CONSENT FOR TREATMENT: The undersigned authorizes Henry Chiropractic Clinic, and its employees to furnish chiropractic treatment deemed appropriate including exams, x-rays, spinal manipulation, or chiropractic physio-therapeutics deemed necessary. I am aware that adverse unforeseen reactions can occur and it is the patient's responsibility to inform the treating chiropractor of any underlying diseases or pathologies he/she is aware of.

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT: Hands or a mechanical device is used on your body in such a way as to cause movement in your joints. This movement may cause an audible "pop" or "click". You may feel or sense this movement.

THE MATERIAL RISKS INHERENT IN CHIROPRACTIC ADJUSTMENT: As with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, muscle injuries, associated vessels, dislocations, and muscle strain, Horner's syndrome, cervical myelopathy, cerebral infarctions and costovertebral strains and separations. Some patients will feel some stiffness and soreness following the first few days of treatment. Through a comprehensive examination, x-rays, and proper orthopedic tests we will screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

THE PROBABILITY OF THOSE RISKS OCCURRING: Although the above risks are rare in occurrence, it is important that you are aware of these risks and understand the meaning of each risk. You are highly encouraged to ask any and all questions that you may have about these risks before signing this Consent.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign payment directly to Henry Chiropractic Clinic, benefits payable to me but not exceed the Clinic's regular charges for this period of treatment. I understand, as a courtesy Henry Chiropractic will file my insurance however, I agree my health insurance coverage is a contract between me and my insurance company. The verification of coverage is not a guarantee of payment and ultimately, I am responsible for all charges incurred. If my insurance does not pay within 60 days of filing, I may be asked to make payment arrangements of total charges.

FINANCIAL AGREEMENT: For services rendered I the undersigned agree to pay all professional and clinic charges. I also agree if account is placed with a Collection Agency for non-payment a collection-fee of up to 33.3% may be added to my account and shall become a part of the Total Amount Due. I will also be responsible for all Reasonable Attorney Fees and Court Cost. If my financial portion owed is putting me or my family in a financial hardship, I will notify Henry Chiropractic and further paperwork will be signed and payment arrangements will be made to make needed care affordable for me or my family.

RETIREMENT/DESTRUCTION OF X-RAYS: I hereby authorize Henry Chiropractic Clinic, to follow the usual hospital practice of retiring x-ray films and any other graphic data, which may be generated during patient's care four (4) years after they are generated, if a report of the findings is retained for the same period as other clinic records. Further, I hereby release and hold harmless Henry Chiropractic Clinic, its officers, staff, and employees, from any liability connected with this procedure.

It is hereby understood that a copy of this shall be as valid as the original.

_____	_____	_____	_____
Signature of Patient or Guardian	Date	Witness	Date

Rev. 11-2021

HENRY CHIROPRACTIC

Helping People Get on the Road to Recovery

8820 Goodman Road, Olive Branch, MS 38654
Phone: 662-890-5454 or 901-521-7271

Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Our Promise!

The confidentiality of your health records has always been very important to us here at Henry Chiropractic and we have gone to great lengths to help assure the privacy of your health information. New federal laws commonly known as HIPAA (Health Insurance Portability and Accountability Act) have been written to further protect your private health information in today's electronic age. We take these laws very seriously and want you to be able to receive your treatment with confidence that your personal health history will not unnecessarily be made available to others outside our office.

So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal Government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to insure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal laws regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purpose of providing your treatment, obtaining payment, and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your

HEALTH INFORMATION

may be used

To Provide Treatment
We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may included administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies, or other health care personnel providing your treatment.

To Obtain Payment
We may include your health information with a invoice used to collect payments for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations
Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing, or credentialing activities.

In Patient Reminders
Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.
These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as, email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect
We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law, or with the patient's agreement.

Public Health and National Security
We may be required to disclose to Federal Officials or military authorities' health information necessary to complete an investigation related public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement
As permitted or required by State or Federal law, we may disclose you health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the care of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners
We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research
Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements, and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Rights
This new law is careful to describe that you have the following rights related to your health information.

Restrictions
You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications
You have the right to request that we communicate with you in a certain way. You may request that we only communicate you health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information
You have the right to read, review, and copy you health information including your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the changes.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information
You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment, or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Patient Signature Date