Welcome

❶ About You

Today's Date: ____/____/_____ Pt. #:________

Patient Name:_______________________________

What you Prefer to be called:________________

SS#:____________________ ☐ Male ☐ Female

Birthdate: _____/_____/_______ Age:_____

Address:___________________________________

City:________________ State: ____ Zip: ______

Home Phone: _______________________________

Work Phone:________________________________

Mobil Phone:________________________________

Email:_____________________________________

Type of automatic reminder for your appointment?

☐Call Home ☐Call Cell ☐Text Cell ☐Email

Referred By:________________________________

Employer:_________________ How Long?_____

Employer's Address__________________________

City:________________ State: ____ Zip: ______

Occupation:_________________________________

Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed

Spouse's Name:_____________________________

Do you have children? ☐Yes ☐No How Many?___

❷ Insurance Info

Primary Insurance

Co. Name:_________________________________

Address:___________________________________

City:________________ State: ____ Zip:_____

Phone #:___________________________________

Insured's SS#:_____________________________

Patient's ID#:_____________________________

Group # (Plan, Local, Policy#)_________________

Insured's Name:____________________________

Relation:_____________ DOB ____/____/____

Secondary Insurance

Co. Name:_________________________________

Address:___________________________________

City:________________ State: ____ Zip:_____

Phone #:___________________________________

Insured's SS#:_____________________________

Group # (Plan, Local, Policy#)_________________

Insured's Name:____________________________

Relation:_____________ DOB ____/____/____

Insured's Employer:_________________________

❸ Account Info

Person ultimately responsible for account

Name:_____________________________________

Relation:___________________________________

Billing Address:_____________________________

City:__________________ State___ Zip_____

SS#:_______________________________________

Drivers License #:___________________________

Work Phone #:_______________________________

Payment Method: ☐ Cash ☐Check ☐Credit

______(Initials) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

❹ In Event of Emergency

Who should we contact?________________________

Relation:____________________________________

Home Phone #:_______________________________

Work Phone #:_______________________________

Who is your Medical Doctor?___________________

M.D.'s Phone #:______________________________

❺ Reason for Visit

Reason for today's visit (circle): Emergency New Injury Old Injury Chronic Pain Wellness

Are you in pain (circle) YES NO Rate your pain on a scale from 1 to 10(1=no discomfort/10=intense) ___

Did your injury occur during (circle) Work Sports/Play Auto Accident Routine/Household activity

When did your condition/accident occur? ___/___/___ Where did your injury occur?_________________

Please explain what happened:____

Is your condition getting worse? YES NO Constant Comes and goes

Is your condition interfering with your: Work Sleep Daily Routine
Is so, How: ____

Has this or something similar happened in the past? YES NO If yes, explain_____________________

Have you been treated by a Medical Physician for this condition? YES NO If yes, where____________

Have you ever been treated by a Chiropractor? YES NO

Clinic/Dr.'s name ____ Clinic Phone ________________

❻ Health History

Are you taking any of the following medications? (circle) Nerve Pills Pain Killers (including aspirin)

Muscle Relaxers Blood Thinners Tranquilizers Insulin Other____

Do you have or had any of the following diseases, medical conditions or procedures?

Y N Heart Murmurs	**Y N** Heart Surg/ Pacemaker	**Y N** Heart Attack/ Stroke	**Y N** Cong. Heart Defect	**Y N** Mitral Valve Prolapse
Y N Artificial Valves	**Y N** Alcohol/Drug Abuse	**Y N** Venereal Disease	**Y N** Fainting/ Seizures/ Epilepsy	**Y N** HIV+/AIDS/ARC
Y N Shingles	**Y N** High/Low Blood Pressure	**Y N** Frequent Neck Pain	**Y N** Difficulty Breathing	**Y N** Anemia/ Diabetes
Y N Cancer	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever	**Y N** Severe/ Frequent Headaches	**Y N** Kidney Problems
Y N Ulcers/Colitis	**Y N** Hepatitis	**Y N** Sinus Problems	**Y N** Emphysema/ Asthma	**Y N** Tuberculosis
Y N Glaucoma	**Y N** Chemotherapy	**Y N** Lower Back Problems	**Y N** Artificial Bones/ Joints/Implants	**Y N** Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:_____________
____

List any past accidents with dates:____

Please list anything that you may be allergic to:____

Family Health History:____

Do you take Supplements of Vitamins? YES NO Do you exercise? YES NO ____hours per week

Do you smoke? NO YES How much?__________ How long?_______________

Are you wearing (circle) Shoe Lifts Inner Soles Arch Supports Are you dieting NO YES since ___/___/___

For women: Are you taking birth control? YES NO

Are you Nursing? YES NO Are you Pregnant? NO YES How many weeks ?______________

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred on collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature______________________________________ Date ____/____/____
(Circle) Adult Patient Parent/Guardian Spouse

Dixon Chiropractic Center, P.C.
Dewey G. Dixon, D.C., C.C.S.P.
426 S. Blanche
Mounds, IL 62964
618-745-6894

CONSENT TO TREAT AND X-RAY

Please fill out the section that pertains to the patient, either section A, B, or C.

A.

I ________________, authorize the performance of diagnostic x-ray examination of myself, which the doctor may consider necessary or advisable in the course of my examination and treatment.

Signed____________________ Date_________________

B.

Females Only

I certify that to the best of my knowledge I am not pregnant and the doctor has my permission to perform diagnostic x-ray examination.

I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period_______________________

Signed_______________________ Date____________________

C.

Minors Only: Parent or Legal Guardian please complete this section.

I hereby authorize __________________ and whomever he/she designate as his/her assistants to administer treatment as he/she so deems necessary to my child, ____________________.

Parent/Guardian Signature__________________ Date_____________

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Authorization

I certify that I have read and understand the information to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dixon Chiropractic Center, Inc. to release and information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Dixon Chiropractic Center, Inc., insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf or my dependents.

X ____

Signature of Patient (or parent of a minor) Date

I authorize Dixon Chiropractic Center to send me any type of health care related publications by mail or email, such as newsletters, birthday letters, etc.

X ____

Signature of Patient (or parent of a minor) Date

I authorize Dixon Chiropractic Center to display pictures of ___________________________ while being adjusted/treated, in their office. These pictures may be displayed within the office, or on social networking sites (Facebook).

X ____

Signature of Patient (or parent of a minor) Date

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Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

___________________________	___________________________
Patient name (printed)	Relationship to patient
___________________________	___________________________
Patient or legal Guardian Signature	Date
___________________________	___________________________
Witness Signature (office staff)	Date

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NOTICE OF PRIVACY PRACTICES

(Medical)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our offices, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPPAA or to file a complaint:

The U.S. Department of Health & Human Services Office of Civil Rights
200 Independences Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ★ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ★ Obtain payment from third-party payers.
- ★ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice to Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Relationship to Patient: ____

Date: ____

Patient Name: ____

Signature: ____

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TERMS OF ACCEPTANCE

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic care.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

1. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.
2. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.
3. The chiropractic adjustment process, as defined in the "law of this jurisdiction" involves the application of a specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one-million times each day by doctors of chiropractic in the United States alone.
4. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
5. Chiropractic does not seek to replace of compete with your medical, dental, of other type(s) of health professionals. The retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
6. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
7. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

I, ____________________ (print name) have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

______________________________ ________________

(Signature) (Date)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

CARRIER

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

X 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

X SIGNED X DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

X SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)