Results Chiropractic Centre DBA:

Flowertown Chiropractic

WELCOME TO OUR OFFICE

CONFIDENTIAL PATIENT HISTORY

Fees are payable at time services are rendered unless other arrangements are made.

ABOUT YOU

TODAY'S DATE _____ PATIENTS NUMBER _____

Name _____ (Last / First / Middle Initial) I prefer to be called _____ ☐M ☐F

DOB _____ Age _____ SS# _____ Marital Status ☐S ☐M ☐D ☐W

Address _____ (Street / City / State / Zip)

Home Ph _____ Mobile Ph _____ Fax _____ Other _____

Email Address _____ Driver License # _____

Occupation _____ Employer _____ Work Ph _____

Spouse _____ SS# _____ DOB _____

Spouse / Insured's Employer _____ Phone _____

Name of person to be billed _____ Address _____ Relationship _____

Emergency Contact _____ Phone _____

Who may we thank for referring you? _____

What hobbies and/or activities do you enjoy? _____

Does your workplace have a health or safety fair? _____ Contact person and phone _____

MEDICAL HISTORY

Have you ever had past Chiropractic Care? Yes ☐ No ☐ If yes, when and why? _____

Chiropractors Name _____ Phone _____

Medical Doctors Name _____ Phone _____

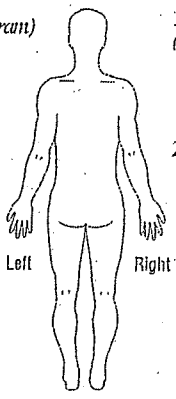
Are you taking any medications? Yes ☐ No ☐ If yes, please list _____

List any allergies _____

Do you smoke or use tobacco? ☐Never ☐Seldom ☐Frequently

PRESENT COMPLAINT

Reason for this visit *(describe symptoms below and follow directions on diagram)*



1. Mark area of pain on diagram
(use below symbols for different types)

≠≠≠ Burning
=== Constant
«««« Sharp
• • • Stabbing

2. List region of pain & circle severity number *(1=least, 10=greatest)*

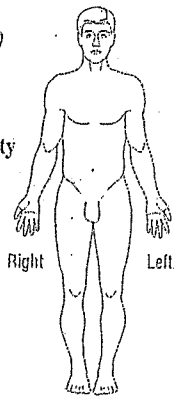
ex. NECK 1 2 3 (4) 5 6 7 8 9 10

a. _____ 1 2 3 4 5 6 7 8 9 10

b. _____ 1 2 3 4 5 6 7 8 9 10

c. _____ 1 2 3 4 5 6 7 8 9 10

d. _____ 1 2 3 4 5 6 7 8 9 10



Treatment rendered, if any _____

When did condition begin? _____

Is problem due to: ☐Auto Accident ☐Work Injury ☐Other _____

If work related, have you reported this injury to your employer? Yes ☐ No ☐

If injury is due to an auto accident/work injury, have you retained an attorney? Yes ☐ No ☐

Attorney's Name _____ Phone _____

SIGN

PLEASE READ BEFORE SIGNING

I understand that chiropractic is a separate and distinct health service. Chiropractic dos not offer to diagnose, heal or treat diseases. The only goal of chiropractic is to correct vertebral subluxations. I understand that Results Chiropractic Centre/Dr. Mennetti does not offer medical services or advice, and they do not discourage me from seeking a medical evaluation. By signing this form, I agree that I am only seeking care for the correction of vertebral subluxations at Results Chiropractic Centre/Dr. Mennetti.

Date: _____ Patients Name (printed) _____ Patients Signature _____

Treatment of Minor: Parent/Guardian Name (printed) _____ Signature _____

Patient Information

We are in the process of updating our records to comply with federal standards. Please answer the following questions for our electronic health record.

Patient Email:

[redacted]_____ **Date:**_____

Preferred Language: O English O Spanish O Other_____

Height: _____feet_____inches Weight:_____

Which are you? O Right handed O Left handed

Number of children_____

Please list out your previous surgeries_____

_____

_____

_____

O I have had NO surgeries

Race:
O I do not wish to provide this information
O White
O Black or African American
O Asian
O Native Hawaiian or other Pacific Islander
O Other – _____

Ethnicity:
O I do not wish to provide this information
O Hispanic or Latino
O Non-Hispanic or Non-Latino
O Other- _____

Smoking Status:
O Current every day smoker
O Current some day smoker
O Former smoker
O Never smoker

Do you have any medication allergies?

O No known allergies
O Yes, allergies and list_____

Are you currently taking any medications?

O NOT currently prescribed any medications

O YES currently taking ....

What?_____ _____mg
What?_____ _____mg
What? _____ _____mg
What?_____ _____mg

Flowertown Chiropractic

Dr. Brian Mennetti

ASSIGNMENT OF PROCEEDS, LIEN, AND AUTHORIZATION

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay, provide or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present or future ("condition") to pay directly and exclusively in the name of Results Chiropractic Centre, Inc., such sums as may be owing to Results Chiropractic Centre for charges incurred by me at the Office relating to my condition ("charges"), with such payments to be made exclusively in the name of Results Chiropractic Centre. I further grant a lien to Results Chiropractic Centre with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein, "Assignment and Lien") "benefits" shall include, but not limited to, proceeds from any settlement, release agreement, judgment, verdict, or attorney retainer agreement, as well as any proceeds relating to commercial health or group insurance, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability coverage, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein, whether in compensation for medical expenses or any other type of damage recognized by law.

In the event that I retain one or more attorneys to represent me in this matter who are not located in South Carolina, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon insurance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office.

I authorize this office to release any information regarding my treatment of pertinent to my case(s) to all payers defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers to release to Results Chiropractic Centre any information regarding any coverage or benefits which I may have including, but no limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this office to file a copy of this Assignment and Lien, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Results Chiropractic Centre to endorse/sign my name on any and all checks listing me as a payee which are presented to this office for payment of an account relating to me, my spouse, or any of my defendants. I further authorize Results Chiropractic Centre to apply my credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless if these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due Results Chiropractic Centre for their services. This Assignment and Lien does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Results Chiropractic Centre for all costs of such collection efforts, including, but no limited to, all court costs and all attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of Results Chiropractic Centre, Inc., and myself. I hereby revoke any previously signed authorization conflict with the terms of the Assignment and Lien.

Date _____ Patient Name (print) _____ Patient Signature _____

Date _____ Custodial Parent or Legal Guardian Name (print) _____ Parent/Guardian Signature _____

Insurance Co. _____ Attorney's Name _____

Claim # _____ Attorney's Phone _____

Claim Adjuster _____

Ins. Co. Phone _____

I, _____ have read and agree to honor the terms of this assignment of benefits upon settlement of this case and make payment directly to Results Chiropractic Centre, Inc., all sums due from any settlement received.

Attorney's Signature _____

Date _____

Flowertown Chiropractic

Dr. Brian Mennetti

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone, number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. Be signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time, however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

☐ _____

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§164.524). We reserve the right to change our privacy practices a described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

☐ _____

Patient Privacy Notice Acknowledgement

This notice is effective as of _____. This notice will expire seven years after the after the date the record was created. I acknowledge that the Privacy Policy of this office is available for my inspection in reception area. May change with out notice.

☐ _____

By signing below, I acknowledge that I have read, understood and initialed the above policies of this office.

Date _____ **Patient name printed** _____ **Personal rep. printed** _____

Patient signature _____ **Personal rep. signature** _____

Authorized provider rep. _____ **Description of personal repis authority to act for the patient** _____

(Please circle all that apply)

Can leave message: at work at home on cell on machine

with anyone with _____