



# potochiro

POTOMAC FAMILY & SPORTS CHIROPRACTIC CENTER

Today's Date \_\_\_\_\_

## PATIENT INFORMATION

NAME: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  Male  Female

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Martial Status  Married  Single  Other Spouse \_\_\_\_\_

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

Cell phone \_\_\_\_\_ Home \_\_\_\_\_

Email \_\_\_\_\_

Social Security # \_\_\_\_\_ (required)

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

Who is your Primary Care Physician? \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

### Complete the following if patient is a minor

Responsible Party Name \_\_\_\_\_ Relationship \_\_\_\_\_

Responsible Party Cell # \_\_\_\_\_ Home or Work # \_\_\_\_\_

## INSURANCE INFORMATION

*Please allow us to photocopy your Insurance Card(s) and Photo ID*

Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Patient relationship to Policy Holder/Insured Party:  Spouse  Child  Other

\*Please be aware that when Insurance requires a patient to obtain a written referral to see a specialist it is the patient's responsibility to bring this to the appointment or confirm with our office that your Primary Care Physican office has done this for you, prior to your appointment. If you are not sure if a referral is required please contact your Insurance Company.

Secondary Insurance Company Name \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

If you have a secondary or supplemental Insurance we will file for you after your primary has processed the claim. However, in the event that the secondary does not pay within 60 days, patients will be billed the balance due.

## PATIENT CONDITION SUMMARY

1. What are your major symptoms? \_\_\_\_\_
2. What does this prevent you from doing or enjoying? \_\_\_\_\_
3. If this is a reoccurrence, when was the first time you noticed the problem: \_\_\_\_\_  
\_\_\_\_\_
4. How did the issue originally occur? \_\_\_\_\_
5. Has it become worse recently?  Yes  No  Same If yes, when and how? \_\_\_\_\_  
\_\_\_\_\_
6. How frequent is the condition?  Constant  Daily  50% of time  Intermittent  Night only
7. How long does it last?  All day  Few hours  Minutes
8. Are there any other conditions or symptoms that may be related to your major symptoms? \_\_\_\_\_  
\_\_\_\_\_
9. Describe the pain?  Dull-Sharp  Numbness  Tingling  Aching  Burning  Stabbing  
Other: \_\_\_\_\_
10. Is there anything that relieves the problem? \_\_\_\_\_  
\_\_\_\_\_
11. What makes the problem worse?  Standing  Sitting  Lying  Bending  Lifting  Twisting  
Other: \_\_\_\_\_
12. List any major accidents you have had other than those that might have been mentioned above:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
13. Women only: Are you pregnant or is there a possibility you may be pregnant  Yes  No  Uncertain

Place an X on the line below to indicate the level of the problem for you and give it a number on 1-10 with 10 being the worse, where you are now, today.



## HIPAA CONSENT AND FINANCIAL POLICY

HIPAA: The practice provides this information to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. By signing below the patient understands:

- Protected health information may be disclosed or used for treatment, payment or health care options.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The practice may condition receipt of treatment upon the execution of this consent.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

## RELEASE OF INFORMATION:

Besides myself, I authorize this practice to discuss personal medical information with the following

person(s): \_\_\_\_\_ and/or \_\_\_\_\_

## INSURANCE AND ASSIGNMENTS OF BENEFITS:

I hereby authorize this practice and its providers to apply for benefits on my behalf for covered services rendered. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier (or in the case of Medicare Part B benefits, to the Social Security Administration the Health Care Financing Administration). A copy of the authorization may be used in place of the original. This authorization may be revoked by either me or my insurance carrier at any time in writing.

I hereby authorize payment of all medical insurance benefits to be paid directly to this practice and/or its providers for services rendered. I understand and agree that I am financially responsible for charges not paid by insurance company. I understand that in certain instances my insurance may decide that medical services are not medically necessary and that payment may be denied for these services. I agree to be personally and fully responsible for payment or any denied charges. If I have Medicare, I understand that I may be asked to sign an advanced notice/waiver for certain services or procedures.

I hereby certify that the information I have provided is correct. I hereby certify that I have read, understand, and agree with the about HIPAA and Financial Policies. I further agree to pay bank charges for insufficient funds, finance charges and/or collection fees assessed to my account for any overdue balances.

Patient Signature/Responsible party \_\_\_\_\_ Date \_\_\_\_\_



## OFFICE POLICIES

### CANCELLATIONS/NO-SHOW POLICY

If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so we can accommodate our other patients. You may also reschedule your appointment at that time.

No show policy: We do require a 24 hour notice of cancellations. If you do not show up to your appointment without notifying us, the first time will be a warning and after that, you will be charged \$75 for the time we were not able to fill when you were a no show.

### MEDICAL RECORD POLICY

Each patient has a complete record of all medical care received at our office. Your personal medical record provides a history of treatment and diagnostic information that enables your health care team to make comprehensive medical evaluations. We consider your record to be confidential. Therefore, information will not be released without your written consent, unless required by law. Copies of your medical record will be released to you or transferred to another physician upon written consent. There will be a \$25-50 copying fee for this service. This must be paid prior to records being released.

### COMPLETION OF FORMS (Family medical leave and disability forms)

A \$25-50 charge will be assessed for the completion of forms outside of an office visit. The charge varies on the length of the form and the time taken to complete.

### REFERRALS

Please be advised that patients are responsible for managing their own referrals and making sure they are covered at time of service. Upon verbal request, our office, as a courtesy, will only be able to provide the referral start and end date to assist in helping determine when referrals will expire. As the patient, this will allow you to request a new referral/ extension in timely manner. Patients are also responsible for communicating with their own PCP and/or insurance companies. We thank you in advance for your understanding and support.

### COLLECTION POLICY

In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding account balances.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### DOCUMENTATION WAIVER

Your signature below signifies that you clearly understand that:

- Our office will file a claim to your carrier
- Certain types of plans will not reimburse our office unless we have proper documentation
- Paperwork must be returned to our office in a timely fashion
- In the event we do not receive the proper documentation and/or our office is not paid, the cost will become the patients' responsibility

*Do not sign this form unless you positively understand the consequences of your visit and the charges you may have to encounter.*

Signature \_\_\_\_\_ Date \_\_\_\_\_



## PATIENT/FAMILY HISTORY

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

Below are lists of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

### Check any of the following diseases you have had:

- |                                    |  |   |  |   |
|------------------------------------|--|---|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Influenza      | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Small pox        |
| <input type="checkbox"/> Pleurisy  | <input type="checkbox"/> Polio         | <input type="checkbox"/> Chicken pox    | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Cancer          | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia    | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago        | <input type="checkbox"/> Measles         | <input type="checkbox"/> Thyroid          |
| <input type="checkbox"/> Eczema    |  |   |  |   |

Have you been tested HIV positive? Yes No

### Personal Intake:

- |                                 |                              |                                  |                                     |                                      |
|---------------------------------|------------------------------|----------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Tea | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Cigarettes | <input type="checkbox"/> White sugar |
|---------------------------------|------------------------------|----------------------------------|-------------------------------------|--------------------------------------|

### Check any of the following you have had the past 6 months:

- |  |  |   |   |   |
|--|--|---|---|---|
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> General stiffness | <input type="checkbox"/> Joint pain/stiffness | <input type="checkbox"/> Neck pain          | <input type="checkbox"/> Pain Between shoulders   |
| <input type="checkbox"/> Arm pain      | <input type="checkbox"/> Walking problems  | <input type="checkbox"/> Heartburn            | <input type="checkbox"/> Black/bloody stool | <input type="checkbox"/> Gas/bloating/after meals |
| <input type="checkbox"/> Colitis       |  |   |   |   |

**FEMALES ONLY:** Last menstrual cycle: \_\_\_\_\_ Are you pregnant: Yes No Unsure

### Genito-Urinary

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Bladder trouble | <input type="checkbox"/> Discolored Urine | <input type="checkbox"/> Difficult chewing/clicking jaw | <input type="checkbox"/> Painful/Excessive Urination |
|--|---|---|--|

### Nervous System

- |   |                                   |                                      |   |  |
|---|-----------------------------------|--------------------------------------|---|--|
| <input type="checkbox"/> Nervous              | <input type="checkbox"/> Numbness | <input type="checkbox"/> Paralysis   | <input type="checkbox"/> Dizziness                        | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> Confusion/Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Cold/tingling extremities/stress |  |

### C-V-R

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="checkbox"/> Chest Pain     | <input type="checkbox"/> Short Breath   | <input type="checkbox"/> Blood pressure issue | <input type="checkbox"/> Irregular heartbeat      | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Lung Problems/Congestion |   |

### General

- |                                  |                                    |  |                                |                                    |
|----------------------------------|------------------------------------|--|--------------------------------|------------------------------------|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Allergies | <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Fever | <input type="checkbox"/> Headaches |
|----------------------------------|------------------------------------|--|--------------------------------|------------------------------------|

### ENT

- |  |  |                                   |   |                                       |
|--|--|-----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Vision issues | <input type="checkbox"/> Dental issues | <input type="checkbox"/> Earaches | <input type="checkbox"/> Hearing issues | <input type="checkbox"/> Stuffed nose |
|--|--|-----------------------------------|---|---------------------------------------|

### Gastro-Intestinal

- |   |   |                                       |  |  |
|---|---|---------------------------------------|--|--|
| <input type="checkbox"/> Hemorrhoids        | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Liver issue  | <input type="checkbox"/> Frequent Nausea | <input type="checkbox"/> Poor/Excessive Appetite |
| <input type="checkbox"/> Gall bladder issue | <input type="checkbox"/> Vomiting         | <input type="checkbox"/> Weight issue | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Abdominal cramps        |
| <input type="checkbox"/> Constipation       |   |                                       |  |  |

### Male/ Female

- |  |   |   |  |  |
|--|---|---|--|--|
| <input type="checkbox"/> Menstrual Irregularity      | <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> Vaginal pain/infection | <input type="checkbox"/> Breast pain/lumps |  |
| <input type="checkbox"/> Prostate/Sexual dysfunction |   | <input type="checkbox"/> Other problems: _____  |  |  |

### Family History:

Do any of the following members have any of the symptoms listed above?

- |  |  |   |   |                                 |
|--|--|---|---|---------------------------------|
| <input type="checkbox"/> Mother          | <input type="checkbox"/> Father          | <input type="checkbox"/> Brother          | <input type="checkbox"/> Sister           | <input type="checkbox"/> Spouse |
| <input type="checkbox"/> Paternal Mother | <input type="checkbox"/> Paternal Father | <input type="checkbox"/> Fraternal Mother | <input type="checkbox"/> Fraternal Father | <input type="checkbox"/> Child  |



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POTOMAC FAMILY & SPORTS CHIROPRACTIC CENTER

**CONSENT TO TREAT A MINOR PATIENT WITHOUT PARENT PRESENT**

In order for us to treat a minor without a parent/legal guardian present, please complete this form:

I, \_\_\_\_\_ am the parent/legal guardian of \_\_\_\_\_  
*(print name here)* *(print name of minor)*

currently a minor, whose date of birth is \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I authorize Potomac Family & Sports to provide medical care to my son/daughter, including but not limited to diagnostic exams and treatment procedures.

I understand that, should my minor child need more invasive care attempts will be made to contact me before such care is initiated.

I further understand that once my child reaches the age of majority, my consent for treatment is no longer required.

This consent will remain in effect until the patient reaches the age of eighteen unless revoked in writing to Potomac Family & Sports Chiropractic Center.

Payment is expected the day of the appointment and can be made by cash, check, or credit card when checking in, or in advance over the phone.

By signing this, I acknowledge I have read and agree to this consent and that any questions I had prior to signing this were answered.

Signature of Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Phone: Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_