Chiropractic Care Center, PLLC

DR. JILL BEATY DR. A. WARREN

102 N CENTRAL
FLETCHER, OK 73541
(580) 549-6932

PATIENT INFORMATION

Patient Name _____
LAST NAME

_____
FIRST NAME MIDDLE INITIAL

Address _____

City _____

State _____ Zip _____

Cell Phone _____ Carrier _____

Home Phone _____

E-mail _____

Social Security # _____

Birthdate _____ Sex: ☐ Male ☐ Female

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ___ years

Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone _____

Spouse's Name _____

Spouse's Employer _____

IN CASE OF EMERGENCY

Name _____ Relationship _____

Cell Phone _____

Home Phone _____

Whom may we thank for referring you?

_____

PATIENT CONDITION

Describe your primary health concern**:** _____ Second: _____

Third: _____ Fourth: _____

When did your symptom(s) first appear? _____

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

Mark the severity of your pain on a scale of 1 (least pain) to 10 (severe pain). _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have pain? ☐ Daily ☐ Once a week

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 ☐ Laying Down ☐ Lifting

HEALTH HISTORY

Have you received chiropractic care before? ☐ Yes ☐ No If Yes, when? _____ Who? _____

What health care have you already received for your current condition?

☐ Chiropractic Care (Dr. _____ Date _____) ☐ Surgery (Dr. _____ Date _____)
☐ Medications (Dr. _____) ☐ Physical Therapy (Dr. _____ Date _____)
☐ Other: _____ (Dr._____ Date_____)
☐ None

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

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Prostrate Problems	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Breast Lumps	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Fractures	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Atherosclerosis (arterial plaque/blockage)	☐ Yes ☐ No				

Other _____

PREGNANCY

Are you currently pregnant? ☐ No ☐ Yes If so, how far along? _____ Nursing ☐ No ☐ Yes

Number of past pregnancies _____

Children's Ages: Child #1 _____ Child #2 _____ Child #3 _____ Child #4 _____

MEDICATIONS	ALLERGIES	SUPPLEMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Informed Consent Document

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment we use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause as audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following:

- Spinal manipulative therapy
- Physical examination
- Range of motion testing
- Muscle strength testing
- Radiographic studies
- Traction
- Rehabilitation
- Physiotherapy
- Nutrition
- Palpation
- Orthopedic testing
- Postural analysis
- Basic neurological testing
- Electrical stimulation
- Cold laser

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractions, disc injuries, dislocations, muscle strain, cervical myelopathy, and vertebral strain and separations.
Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention; it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we ask about on the health history form. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which my set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interested to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Patient's Signature and/or Guardian _____ Date: _____

FEMALES ONLY → *Please read carefully and check boxes, include the appropriate date, and then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

□ The first day of my last menstrual cycle was on ____/____/_____ date.

□ I have been provided a full explanation of when I am mostly to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with the exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient's Signature and/or Guardian _____ Date: _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk or in the lobby area before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature and/or Guardian _____ Date: _____

Office Financial Policy

CO-PAYS

All patients with co-pay are required to pay their co-pay at the time of service, prior to services rendered

INSURANCE DEDUCTIBLES

All patients with a deductible plan are required to pay the allowed amount each visit until the deductible has been met.

NO INSURANCE CARD AT THE TIME OF VISIT

Any patients who do not have their insurance card or information needed to verify coverage/benefits may be responsible for full payment of the visit until insurance information is provided to our office.

INSURANCE UPDATES

It is your responsibility to provide our office with insurance changes/updates. If you fail to provide this information to us you may be responsible for paying the full amount of the visit.

INSURANCE CHARGES

Charges are decided by your insurance company, *not our office*. In the event we are not aware of a charge that is not covered by your plan, you will be billed after we obtain a denial from your insurance carrier.

If you will be filling insurance please fill in the blanks then sign in the appropriate area.

I certify that I, and/or my dependent(s), have insurance coverage with _____ company and assign directly to Jill Beaty, D.C. 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 authorize the use of my signature on all insurance submissions. The above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient's Signature and/or Guardian _____ Date: _____

Primary Insurance

Person Responsible for Account _____
LAST NAME FIRST NAME M.I.

Relationship to Patient _____ Date of Birth _____

Is the patient covered by additional insurance? ☐ Yes ☐ No

If so, Name of Insurance Company _____

Person Responsible for Account _____
LAST NAME FIRST NAME M.I.

Relationship to Patient _____ Date of Birth _____

INSURANCE ELIGIBILITY AND BENEFITS

Our staff does their best to verify your insurance at the time of your visit but this is only a quote from your insurance and not a guarantee of payment. Ultimately you as the patient are responsible for understanding your contract with your insurance carrier.

MEDICARE

Medicare pays for chiropractic adjustments but it does not pay for other chiropractic care such as x-rays, exams, or therapy. This means you will be responsible for any services not covered by Medicare. If you have supplemental insurance it may pay for some or all remaining charges.

SELF-PAY

All patients who are self-pay are required to pay the full amount at the time of service unless prior payment arrangements have been made.

CHUSA

We are providers for ChiroHealth USA, which is a program you may join that allows members to receive a discounted fee.

OUTSTANDING BALANCES

Our office will send out patient statements at the beginning of every month. Statement balances will be due the first day of the following month. If the entire balance is not paid, or payment arrangements have not been made, late charges on the unpaid balance will be assessed.

COLLECTION AND SMALL CLAIMS COURT

If your account is sent to a collection agency or small claims court, additional fees will be incurred. These charges, along with the balance will be your responsibility in full. No additional visits will be scheduled until the account has been cleared from the collection agency or court judgment has been issued.

RETURNED CHECK FEE

A $20.00 fee will be added to your account for all returned checks in addition to the amount of the check returned.

I have read and understand Dr. Jill's Chiropractic Care Center's Financial Policy outlined above.

Patient's Signature and/or Guardian _____ Date: _____

Authorization for Release of Information to Family Members

Patient Name: _____ Date of Birth: _____

Many of our patients all family members such as their spouse, parents or other to call and request medical or billing information under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Dr. Jill's Chiropractic Care Center to release my medical and/or billing information to the following individual(s):

1._____ Phone:_____ Relation to Patient:_____

2._____ Phone:_____ Relation to Patient:_____

3._____ Phone:_____ Relation to Patient:_____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature: _____ Date: _____