Patient Health History

Today's Date [/ /] **Signature of Patient** ______________________________

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name______________________ **Nick Name**______________________

Last Name ______________________ **Middle Name** ______________**Suffix** ________

Address 1 ____

Address 2 ____

City______________________ **State**__________ **Zip Code** ____________

Primary Phone ____________________**Secondary Phone** ____________________

Mobile Phone ______________ **Cell Carrier** ______________________________

Would you like to receive a text message appointment reminder? Yes No

Home email ____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

*****IMPORTANT***** *Email address is only for a clinical summary which is required. No marketing materials will be sent to your email address.*

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth [/ /] **Age** ________ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** ____________________

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other_________ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Continued …

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1)		**5)**	
2)		**6)**	
3)		**7)**	
4)		**8)**	

Name of Family Physician:_________________________ **Name of Pharmacy Used:**__________________

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) ________________________ **3)** ________________________

2) ________________________ **4)** ________________________

Briefly list your main health problems: ________________________

____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _______________

____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ________________________

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: ______inches **Weight:** __________ pounds **BP:** _______ / ________

SPO^2:__________**%** **HR:**________**BPM** **RESP:**__________ **TEMP:**___________

GENERAL PATIENT INFORMATION

(Please print clearly)

Name ______________________________ **Date** _______________________________

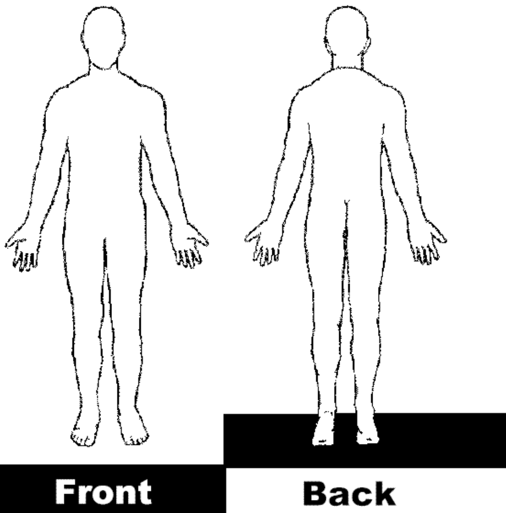
Employer ___________________________ **Occupation** __________________________

Who can we thank for referring you to our office? ____

Please list the reason(s) for your visit here, in order of primary importance, and then rank the average level of pain experienced for each complaint (**0 is absent pain and 10 is very severe pain**) and then describe how often you typically experience pain symptoms.

Symptom	Date first noticed	Average Pain Level (0-10)	How often experienced

Please mark the areas of discomfort or pain on the figures below using the symbol that best describes the feeling:



+++Sharp or shooting
VVV Dull or aching
OOO Pins and Needles
/// Numbness or Tingling

What do you think caused your problem?

____

What activities of your daily life are limited by the pain?

____

Do you have any past history of specific incidental trauma (Motor Vehicle Collisions, Sports Injuries, Significant Falls, Lifting Injuries, Work Related Injuries)? **YES / NO**
If yes, please explain with relative dates and type of injury: ___________________________________

____

Do your pain symptoms typically feel worse (please circle): **AM PM Mid-Day Night Constant**

Are you currently seeing any other healthcare professional for any other conditions at this time? **YES / NO**
Name of Doctor:__________________________ **Clinic & Phone**:__________________( )____________

Do you have a history of an overnight hospital stay and/or any surgical history of any kind? **YES / NO**

1. ______________________________________ Year ________________________
2. ______________________________________ Year ________________________
3. ______________________________________ Year ________________________

Please complete the box for all illnesses you have or have had: (**1=have had; 2=currently have**)

( ) Atrial Fibrillation
( ) Angina Pectoris
( ) Artificial Heart Valve
( ) High Blood Pressure
( ) Pacemaker
( ) High Cholesterol
( ) Heart Attack
( ) Bleeding Disorder
( ) Emphysema
( ) Asthma
( ) Tuberculosis
( ) Stroke
( ) Diabetes
( ) Osteoporosis

( ) Colon Polyps
( ) Irritable Bowel
( ) Ulcers
( ) Crohn's Disease
( ) Ulcerative Colitis
( ) Liver Cirrhosis
( ) Hepatitis
( ) Gallstones
( ) Lactose Intolerance
( ) Pancreatitis
( ) Diverticulosis
( ) Anemia
( ) Latex Allergy
( ) Thyroid Disorder

( ) Cancer: Colon
( ) Cancer: Esophagus
( ) Cancer: Stomach
( ) Cancer: Pancreas
( ) Cancer: Prostate
( ) Cancer: Breast
( ) Excessive Alcohol Use
( ) Drug Abuse
( ) Depression
( ) Anxiety
( ) HIV/AIDS
( ) Migraine Headache
( ) Endometriosis
( ) Arthritis

( ) Other ______________

REVIEW OF SYSTEMS

Symptoms		**Physician Comment**
Lack of energy	Yes No	**Constitutional**
Trouble sleeping	Yes No	
Weight loss (10 lbs. in 1 yr.)	Yes No	
Weight gain (10 lbs. in 1 yr.)	Yes No	
Fevers	Yes No	
Hard or infrequent bowel movements	Yes No	**GI**
Loose or frequent bowel movements	Yes No	
Blood in bowel movements	Yes No	
Vomit blood	Yes No	
Heartburn/indigestion	Yes No	
Food sticks when swallowing	Yes No	
Painful swallowing	Yes No	
Yellow jaundice	Yes No	
Chest pain	Yes No	**Cardiovascular**
Irregular heartbeat	Yes No	
Palpitations	Yes No	
Swollen legs	Yes No	
Fainting	Yes No	
Shortness of breath	Yes No	**Respiratory**
Wheezing	Yes No	
Coughing up blood	Yes No	
Asthma	Yes No	
Frequent urination	Yes No	**GU**
Blood in urine	Yes No	
Difficulty urinating	Yes No	
Bladder infections	Yes No	
Kidney stones	Yes No	
Loss of bladder control	Yes No	
Painful menses	Yes No	

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care which may include the use of diagnostic imaging. By signing this form, I hereby authorize these procedures to be performed. I also give authority for the images to be read by an external Radiologist if deemed appropriate by Dr. Linn. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

I hereby authorize the providers of Linn Family Chiropractic, P.C. to administer such procedures as may be deemed necessary in the diagnosis and treatment of the patient. I hereby authorize release of any medical information regarding this visit to my insurance and or primary care physician, and also ASSIGN to the Provider all payments from Medicare, Midlands Choice, Blue Cross/Blue Shield, Medicaid, and my insurance if not listed. I Understand that I am financially responsible for all charges whether or not paid by my insurance.

I Understand that not all providers at Linn Family Chiropractic, P.C. may be a participating provider with my insurance. I Understand that I am responsible for the charges not covered by my insurance. A late fee of $17.50 plus interest with a minimum of $3.00 will be added to all accounts unpaid for 90 days. I will also be liable for all legal and collection fees. I understand and Agree to the above conditions.

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: ____________________________ Patient's Signature: _________________________ Date: __________

Consent to treat a Minor: ________________________________ Date: _____________

Guardian or Spouse's Signature of Authorizing Care: _________________________________ Date: _____________

Payment for services is due on the day of service. As part of our service, we will submit your claim to your insurance.

VERIFICATION OF NOT PREGNANT (for females only)

This is to certify that to the best of my knowledge; I am not pregnant, and the above doctor and his associates have 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_________________

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

(“Consent Form”)

For the purposes of this Consent Form, “Office” shall refer to: [Linn Family Chiropractic, P.C.].

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office’s privacy notice entitled, “Our Privacy Practices.” I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office’s privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print):

____

Signature:
____

Date: ____/____/____

FINANCIAL POLICY AND AGREEMENT

[Linn Family Chiropractic, P.C.]

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Definitions. In this Agreement, "Office" and "Clinic" shall refer to [Linn Family Chiropractic, P.C.] located at [4307 23rd Street Columbus NE 68601-8507]. "Financial Policy" or "Agreement" shall refer to this document.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase, "(by [Linn Family Chiropractic, P.C.])," shall serve as a properly authorized endorsement. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time; I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office promptly upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. I agree that any delay by the Office in making demand for payment, any delay in paying the full amount of my Charges, and any partial payments received by the Office towards my Charges, shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full promptly upon demand, and shall not constitute an "accord and satisfaction" of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments. I also agree that my account with your Office shall be construed as in "default" on the earlier of the following dates: (a) a Payer fails to pay any or all of the Charges in-full and directly to the Office upon receipt of those Charges within thirty (30) days or the period established by the earliest prompt pay deadline applicable to the Payer (whichever occurs later), (b) I do not pay any or all of the Charges in-full within fourteen (14) days of request, or (c) the Office attempts to charge my credit card in compliance with a written Payment Arrangement, but the charge is declined or not approved.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). For example (without limiting this Agreement), I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I further understand that a Payer may Deny Payment stating that the individual provider who actually renders the treatment or procedure is out-of-network. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I also understand that a Payer may require certain Charges to be pre-certified or pre-authorized. In the event that my condition arose from an accident, I further agree to the terms of the Office's Auto / Work Comp Advance Beneficiary Notices as applicable. I understand that there may be many other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I agree that if I have any questions about the Terms of Non-Coverage, I can request copies of the Office's verification (e.g., eligibility, pre-authorization) forms to gain further understanding. I agree that should the Office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or the Office may in my opinion not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office responsible or liable in any of the foregoing instances.

Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any and all Payers, including without limit in accident cases my health benefit plan, but not including Medicare. Notwithstanding the foregoing, in the event that the Office determines in its sole discretion that it has any reasonable basis for either submitting or not submitting my Charges and/or other documentation to a Payer, I hereby authorize the Office to take such action without condition or restriction. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said Payers in writing, or (b) law expressly imposes on the Office to accept (collectively, "Mandatory Fee Reductions"). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are imposed on the Office by virtue of laws which regulate or restrict "balance billing," I hereby waive the application of such laws to the extent permitted by law. In the event that no Mandatory Fee Reductions are actually imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located and is performable in the county where the Office is located. In any action based upon this Agreement, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum inconvenience. I further waive any statute of limitations which may apply in any action based upon this Agreement. I have reviewed the Office's "Assignment & Lien", Health Insurance Election, and, if applicable, Auto / Work Comp Advance Beneficiary Notices, and further agree to the terms and definitions set forth in these documents as applicable. Said documents are incorporated herein by reference. In the event that my condition is related to an accident, including without limit automobile accident, I understand that there will be an administrative fee necessary to cover the costs of verifying multiple Payers, filing and terminating liens, and submitting notices of same to Payers.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (print): ________________________________ Patient Signature: ____ Date: ____/____/____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): ____

Parent/Guardian Signature: ____ Date: ____/____/____

Linn Family Chiropractic, P.C.
Authorization to Release Health Information

Patient Name: ________________________________ Date of Birth:__________________

Telephone:_____________________ Social Security Number:______-_____-_____________

Address: ____

Other Names Patient Has Used: ____

Send Records To: Linn Family Chiropractic, P.C.
4307 23rd Street
Columbus, Nebraska 68601-8507
(402) 564-6565

I authorize this information to be faxed to (402) 564-0003. This information is being disclosed for the purpose of continuing healthcare.

I authorize the release of [ ] All Health Records -or- (check appropriate boxes)

[ ] History & Physical Exam [ ] Treatment Notes & Documentation

[ ] Radiology Reports/Images [ ]Laboratory Results

[ ]Other: ____

I understand that specific information to be released may include AIDS or HIV, alcohol and/or drug abuse history, and mental health information.

I understand that if I request copies of records for myself or a member of my family, a review of this information with my physician or another healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

Unless otherwise indicated, this authorization will expire one hundred-eighty (180) days from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.

________________________________ ______________________ __________

Signature of Patient or Legal Representative Relationship to Patient Date