Crosby Chiropractic and Wellness Center

Patient Introduction

Your Name: ____
First Middle Last

Your Address: ____

____

Telephone: Home:______________________ Bus: __________________

Cell: ______________________

Email: ____
(Please note that this email address will be kept strictly confidential and will only be used for educational purposes)

Insurance Card: ____
(Please bring health card to front desk)

Birth Date: Month: ___________ Day: _____________ Year: __________

Social Security #: _________________ Marital Status:___________

Occupation: ____________________________

Employer: ____________________________

Previous Chiropractor: __________________________ City: _____________

Last visit to this Chiropractor:____________________

Reason for leaving:____

____

Present MD: ____________________________________ City: _____________

Referred to our Center by:____

Crosby Chiropractic and Wellness Center

Adult Consultation History

Your Name: ____

Your Main Complaint: ____

Any other Complaints: ____

How long have you suffered with this problem? ______________________________

What have you tried to do to get rid of this problem that **DID NOT** work? ____________

____

____

Have you become discouraged about handling this problem? ____________________

When your problem is at its worst, how does it make you feel? __________________

____

How does this problem interfere with the following areas of your life?

WORK: ______________________________________

FAMILY: ______________________________________

HOBBIES: ______________________________________

LIFE: ______________________________________

Does handling this problem cause stress for you? ______________________________

____

What do you do that makes this problem worse? ______________________________

____

How much older does this make you feel: ______________________________________

What gives you some temporary relief? ______________________________________

What is the pattern of this problem? Constant __ Intermittent __ Occasional ___ Cyclic __

What is the effect it has on your body functions? ______________________________

Crosby Chiropractic
and
Wellness Center

How did it start? ____

Are you on any type of medication?________, Please list all: ________________________

____

Could your problem have been caused by an injury at work?_________________________

If yes, please give us the details: ____

Have you been involved in an auto accident? ____________________________________

Date of accident: _______

Any difficulties from this?____

____

Do you have any children? ____

Do they have any health problems that you are aware of? __________________________

____

Is there any other information you would like us to know?__________________________

____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: __________

SIGNATURE: _________________________________ DATE: ________________________

For Women Only

Date of your last menstrual period: ___________________

Are using any means of contraception? ___________________________

Do you experience severe cramping with your menstrual period? _____

Do you suffer from PMS? _________________________________

Thank You!

Crosby Chiropractic and Wellness Center

This office is pleased to accept you case on assignment as soon as we verify your coverage with your insurance company or responsible party. We will file your claim forms to assist you in every way we can for reimbursement. However it must be understood that insurance contracts are between you and your insurance company.

I certify that I, and/or my dependant(s) have insurance with ___________________ and assign directly to Dr. Rob Rosenbaum all insurance benefit, in 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 doctor may use my health care information and may disclose such information to 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.

You are responsible for any amount not paid by your insurance company. Your insurance company should pay within 30 days. If your insurance company has not paid within 60 days then you are required to pay the balance due. You will be reimbursed by your insurance company if and when it pays.

We will do all we can to help you obtain your insurance benefits but we will not enter into a dispute with your insurance company. This is your responsibility and obligation since the contract is between your and your insurance company.

If you understand and agree with all the above policies, sign your name below and we will accept your insurance.

____

Signature of Patient, Parent, Guardian or Personal Representative

____

Please print name of Patient, Parent Guardian or Personal Representative

____

Date **Relationship to Patient**

Crosby Chiropractic and Wellness Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _________________________, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Crosby Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

________________ **Date**

____________________________________ **Signature**

____________________________________ **Print Name**

FOR USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has mad a good faith effort to obtain an acknowledge of _______________ (patient's name)'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ☐ Patient Unavailable
- ☐ Patient Physically Unable
- ☐ Patient Unwilling

In an effort to obtain the patient acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

- ☐ Personally
- ☐ Mail
- ☐ Other: ____

________________ **Date**

____________________________________ **Signature**

____________________________________ **Print Name of Physician**

Crosby Chiropractic
Name of Practice

Crosby Chiropractic and Wellness Center

Consent for Purposes of treatment, Payment and Healthcare Operations

I, _________________________, consent to Crosby Chiropractic's use of disclosure of my Protected Health Information for the purpose of providing treatment to me, for purpose relating to the payment of services rendered to me, and for the Practice's general healthcare operation purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" mean any information, including my demographic information, created or received by the Practice, that relates to my past, present or future physical or mental health or condition; the provision of health care to me; of the past, present or future payment for the provision of health care service to me and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operation of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

____
Signature of Patient of Personal Representative

____
Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority