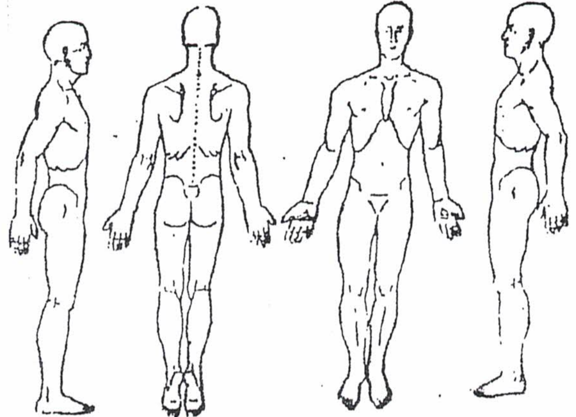
PATIENT HISTORY

Name____Date of Birth ____________________
Address______________________________________City_____________State______Zip__________
Home Phone________________Cell Phone ________________Age__________ Sex: M F
[redacted] Marital Status: S M D W Spouse's Name____________________
Your Employer______________________________________Employer Phone ______________
Your Occupation____
Date when your symptoms started?____
Insured Name______________________________Insured DOB ______________________
Insured Insurance ID#____________________________________Insurance Group #__________
Insurance Company Name____
Insured Employer____
Do you have Secondary Insurance: Y or N If so, Insurance Company Name_______________
Insured Insurance ID#________________________________Group #______________________
Was this incident due to a recent motor vehicle accident? Y or N Date of accident:__________
How did you hear about our Clinic: ____Dr. Referral: Drs. Name___________________________
____Insurance Co. ____Phone Book ____Patient Referral - Pts. Name:___________________
____Walk-In or Walk-By ____Website ____YELP ____Google
Please list your Primary Physician:____
Your E-Mail Address:____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I also understand that if I suspend or terminate any treatment any fees for professional services rendered me will be immediately due and payable.

HABITS

____Smoking Packs/Day_____
____Drinking Alcohol_______
____Coffee Cups/Day_____



INDICATE ON THE DIAGRAM THE AREAS YOU ARE PRESENTLY EXPERIENCING PAIN. CIRCLE YOUR PAIN LEVEL: 1 2 3 4 5 6 7 8 9 10

EXERCISE

_____None _____Moderate _____Daily

FAMILY HISTORY:

	Diabetes	Heart	Kidney	Cancer	Back
Mother	___	___	___	___	___
Father	___	___	___	___	___
Brother	___	___	___	___	___
Sister	___	___	___	___	___

DO YOU HAVE A PACEMAKER? Y or N   Women are you pregnant? ____Yes ____No

Have you had any of the following diseases?

___Aids ___Alcoholism ___Anemia ___Arthritis ___Cancer ___Diabetes
___Heart Disease ___Mental Disorder ___Polio ___Tuberculosis

List any Allergies____

Patient's/Guardian's Signature___________________________________Date_______________

PATIENT:______________________________________DATE:_________________________

CHIEF COMPLAINT:____
____
____

HOW LONG have you been experiencing this problem?______________________________

If there was a NEW problem, was there a cause? YES / NO if YES, what was the cause?
____
____
____

If CHRONIC has it gotten worse? YES / NO If YES, please explain:__________________
____

Any OTHER TREATMENT for this problem? YES / NO if YES what other treatment did you receive?____
____

Is there any position or treatment that RELIEVES THE PAIN? YES / NO If YES, what relieves it?____
____

Is there any position or activity that MAKES THE PAIN WORSE? YES / NO If YES, please explain.____
____

Please circle what best DESCRIBES YOUR PAIN: DULL, SHARP, BURNING, ACHING
____

Does the PAIN TRAVEL to any other area? YES / NO if YES, please explain: __________
____

Please circle when the PAIN is WORSE: MORNING OR EVENING
____

MEDICATION - Please list type and frequency.
____
____
____
____
____
____

Have you had CHIROPRACTIC CARE before? YES / NO if YES, please list
Doctors Name:____
RESULTS of Chiropractic Care:____________________________________
____

Have you experienced any BOWEL or BLADDER dysfunction in the last 6 months?
YES / NO If YES, please circle: BOWEL OR BLADDER
____

Have you had any change in your APPETITE in the last 6 months? YES / NO If YES,
please circle: INCREASE IN APPETITE or DECREASE IN APPETITE
____

Have you had any WEIGHT LOSS or WEIGHT GAIN in the last 6 months?
YES OR NO If YES, please circle: GAIN or LOSS
____

Have you ever been HOSPITALIZED recently? YES / NO If YES, please explain:
____
____
____
____

Please list SURGERIES:____
____
____
____

Have you had any SPORTS RELATED ACCIDENTS? YES / NO If YES, please
explain:____
____

Have you had any MOTOR VEHICLE ACCIDENTS? YES / NO If YES, please
explain:____
____

Are there any other MEDICAL CONCERNS that have not been addressed above?
YES / NO If YES, Please list concerns:______________________________
____

HIPPA PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any whom we may inform about your general medical condition and your diagnosis (including treatment, payment and healthcare operations):

   ____

   ____

2. Please list the family member or significant others, if any whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   ____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent:

   ____

   ____

4. Please list the phone number where you want to receive calls about your healthcare information and appointments:

   ____

   we are fully aware that a cell phone is not secure and private

5. Can confidential messages (i.e., appointment reminders) be left on your cell phone, home telephone answering machine, or work phone (if number was provided)? YES_____ NO______

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to make available to you a copy of our privacy policies and procedures. We encourage you to read this document information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that a copy of the Notice of Privacy Practices for Protected Health information for this office has been made available to me. I understand that I will be given a copy of this document upon my request.

______________________________ ______________

Print Patient's Name Date

____

Patient's/Guardian's Signature

CAMPBELL CHIROPRACTIC CLINIC

Informed Consent

I herby request and consent to treatment from this doctor/clinic including the performance of chiropractic adjustments and other chiropractic procedures, including physical medicine therapy and rehab, examinations, or other testing for my condition.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I fully understand that results are not guaranteed.

I understand and am informed that, as with all treatments, in the practice of chiropractic there are some risks. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise clinical judgment during the course of the procedure, which the doctor feels at the time, based upon the fact then known to him/her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to begin treatment.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I may continue to seek treatment from this facility.

______________________________ ____________________

Patient's/Guardian's Signature Date

OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

Our office will accept your insurance on assignment. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. **All charges incurred are your responsibility.**

Our office will file your claims for you and assist you in every way possible to ensure benefit recovery.

Please read the following office policy regarding assignments:

1. At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office DOES NOT guarantee your insurance policy or payments.
2. Our insurance will be filed as a courtesy to you. We file insurance claims on a weekly basis.
3. You are required to sign an "Assignment of Benefits" form and any other Forms required by your insurance company on your first visit.
4. If your insurance company requires their own claim form(s) you are required to bring in the completed form(s) by your second visit.
5. You will be responsible for your deductible and co-payment. If your insurance company does not pay something that was anticipated, you will be responsible for the amount due as soon as we/you are aware of the denial.
6. Your insurance should pay within 60 days from the date it was filed,
7. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to pay.
8. If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.
9. Any overpayment made by your insurance company, which results in a credit on your account, will be refunded back to them. However, any overpayments or errors in amounts paid which does not credit your account will be your responsibility.
10. If you discontinue care without the doctor's authorization, the balance on your account is due and payable immediately, even if your insurance has been filed. (If your insurance does pay after your account has been paid, a refund will be issued.)

I have read and understand the policy regarding insurance assignments. I realize that I am responsible for all charges incurred by me at this office.

______________________________ ______________________________

Signature Date

NO-SHOW POLICY

We try to maintain a schedule that allows us to see patients in a timely manner. If you are unable to make your appointment, you need to contact the clinic so that we can reschedule your appointment and open the schedule for other patients who may want to make an appointment. As such, as of 9/27/2023, Campbell Chiropractic is instituting the following no-show policy:

For chiropractic visits, if you must cancel or reschedule your appointment we require a **6- hour** notice. We will charge **$30** for any appointment that is missed or not canceled/rescheduled with less than a 6-hour notice. This fee is not covered by any insurance carriers and will be billed directly to the patient.

For massage visits, if you must cancel or reschedule your appointment, we require a **24-hour** notice. We will charge **$40** for any appointment that is missed or not canceled/rescheduled with less than a 24-hour notice. This fee will be billed directly to the patient.

If you have any questions regarding this policy, please ask Dr.Pagano. By signing, you are stating that you understand the No-Show policy.

PATIENT'S SIGNATURE: ______________________ DATE: ______________