NEW PATIENT INFORMATION

Today's Date ___/___/_____

GENERAL INFORMATION

____
Patient Last Name First MI

What You Prefer to Be Called____________

____
Mailing Address

____
City State Zip Code

Home Phone: ( )___________________
Mobile Phone ( )___________________
Work Phone ( )___________________

Date of Birth___/___/____ Age_________

SSN ____________________ Sex_________

Email Address_________________________

Preferred Method of Contact: (Circle One)
Phone Call **Email** **Text Message**
Contact Method(s) NOT to use: (Circle)
Phone Call **Email** **Text Message**

Emergency Contact____________________

Emergency Contact Phone_______________

____
Marital Status Spouse Name # Children

____
Occupation Employer

____
Primary Care Physician Address

INSURANCE INFO

Insurance Co. Name_____________________

Address_______________________________

____
City State Zip

Phone Number: ( )____________________

ID#:_________________________________

Group #:______________________________

Insured's Name_________________________

Relation to You _______________________

Insured's Date of Birth _________________

Have you ever had chiropractic care?_______

When?________________________________

Doctor's Name__________________________

Were you satisfied?______________________

If no, please list reasons for

dissatisfaction__________________________

____

Over 70% of our patients bring in their spouse and/or children to get adjusted. If you would like to have your family treated, check the box below and they can receive a Complimentary 30min Massage with their 1st visit if scheduled within 2 weeks of your starting care!

☐ **I would like my family members treated in the next 2 weeks.** *You have the right to rescind within 72hrs any obligation to pay for goods or services in addition to the free or discounted services. This does not apply to Federal programs, such as Medicare or Medicaid.

FREE OFFER!

NEW PATIENT INFORMATION (Page 2)

How did you hear about our office? Circle One

Friend **Relative** **Yellow Pages** **Newspaper**

Internet **Insurance Provider List** **Mail**

Which one of our patients should we thank for referring you?____________________

Are your present problems due to an auto accident or work injury?_______________

If yes, list claim number _______________

Date of Injury_______________________

List any surgeries and dates____________

____

____

List accidents and dates_______________

____

____

List all conditions which you are being treated for (ie: High Blood Pressure, Diabetes, etc)

____

____

List any medications and vitamins _________

____

____

____

____

Females: Are you or could you be pregnant?__

If yes, how many weeks?_______________

I understand and agree that I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. Further, I understand that this healthcare provider will prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. However I clearly understand and agree that all services rendered to me are my personal responsibility for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. I understand that there is no guarantee of treatment results. Even if my results are not optimal, I am still responsible for my account balance. It is understood and agreed that x-rays will not be released if there is a balance on my account.

____

Printed Name

____

Patient/Guardian Signature

____

Date

Lexington Family CHIROPRACTIC
You don't have to live with the pain!

CURRENT COMPLAINT HISTORY

Patient Name:____Date:__________________

Please list your present complaint(s)-If you have more than one area of complaint, list them in order of most severe to least severe.

1.______________________________________Duration(How Long/Date):________________#of Previous Episodes_____

2.______________________________________Duration(How Long/Date):________________#of Previous Episodes_____

3.______________________________________Duration(How Long/Date):________________#of Previous Episodes_____

Please check all boxes that apply to your condition and fill in the spaces that describe your present complaint(s). Also, the information you provide concerning past symptoms will help in assisting the doctor to better understand your present complaints and total health picture.

Has anyone treated you for this episode? □Yes □No If Yes, by whom?____

How did your symptoms begin?
□Immediately after a specific incident □After multiple incidents □Gradually developed over time □Other_______________

What makes your symptoms better?
□Nothing □Lying Down □Standing □Sitting □Movement/Exercise □Other____________________________________

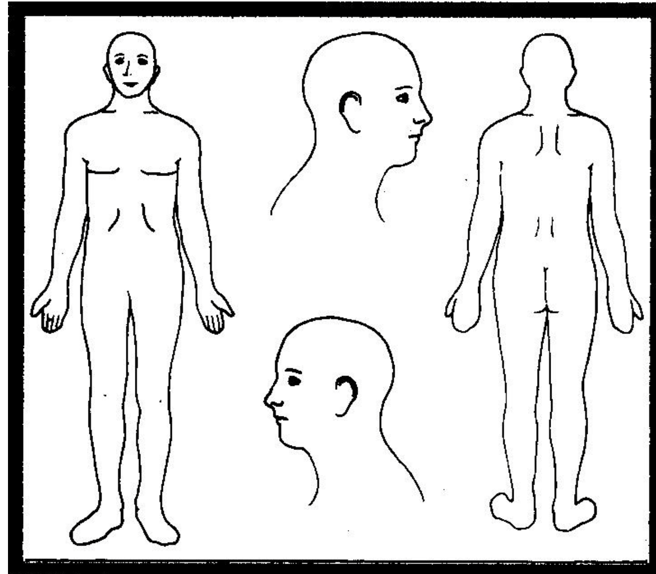
What makes your symptoms worse?
□Nothing □Lying Down □Standing □Sitting □Movement/Exercise □Other____________________________________

Description of pain or symptoms:

□Sharp □Shooting
□Dull □Burning
□Ache □Numb
□Weakness □Tingling
□Throbbing □Other_______________________

SHOW US YOU PAIN—USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SYMPTOMS TODAY

A= ACHE **B**= BURNING **N**= NUMBNESS **S**= STABBING
P= PINS & NEEDLES **X**= STIFFNESS **T**= THROBBING **O**= OTHER



Does your pain move or radiate?
□Yes □No Where________________________________

Check the best and worse time of the day for you pain:

Worse	Best
□First Awake	□First Awake
□Morning	□Morning
□Afternoon	□Afternoon
□Evening	□Evening
□Nighttime	□Nighttime
□Other	□Other

Frequency of pain or symptoms:
□Constant (76-100%)
□Frequent (51-75%)
□Occasional (26-50%)

How many days on an average week are you in pain? (Please circle one) 1 2 3 4 5 6 7

How much time during the day are you in pain? □less than 1hr □1 to 6hrs □6 to 12hrs □12 to 18hrs □18 to 24hrs □24hrs

Patient's/Guardian's Signature:____Date:_________________________

NOTICE OF PRIVACY PRACTICES

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- For payment purposes, we may use the services of a billing service.

I consent to the use or disclosure of my protected health information by Lexington Family Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Lexington Family Chiropractic. I understand that diagnosis or treatment of me by Dr. Heath Gallentine may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Lexington Family Chiropractic is not required to agree to the restrictions that I may request. However, if Lexington Family Chiropractic agrees to a restriction that I request, the restriction is binding on Lexington Family Chiropractic.

I have the right to revoke this consent, in writing, at any time, except to the extent that Lexington Family Chiropractic has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Lexington Family Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Lexington Family Chiropractic. This Notice of Privacy Practices also describes my rights and Lexington Family Chiropractic's duties with respect to my protected health information.

Lexington Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices, and will make available to all patients any and all revised and current notices.

_______________________________________ _______________________________________

Printed Name Date

____

Patient/Guardian Signature

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

My insurance company and/or attorney are hereby requested and authorized to pay by check made out and mailed to:

Dr. Heath Gallentine; Lexington Family Chiropractic
131 Prosperous Place #15
Lexington, KY 40509

Or

If my current policy prohibits direct payment to Doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

__________________________ (Print Name)
C/O Lexington Family Chiropractic
131 Prosperous Place #15
Lexington, KY 40509

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered, the same to be deducted from any settlement on my behalf. I hereby give a lein to Lexington Family Chiropractic against any settlement received to me as a result of the injuries or illness for which I have been treated. I also authorize Dr. Heath Gallentine to deposit a check received on my account from the insurance company when made out to me. THIS IS A DIRECT ASSIGMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I, the undersigned, agree to pay Lexington Family Chiropractic the full amount of charges, should my condition be such that it is not covered by my policy, or if,for any reason,my insurance company refuses to pay my claim.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Even though Lexington Family Chiropractic may verify my insurance coverage, I understand that this is not a guarantee of insurance coverage. Also, I understand that even though I have insurance and benefits are payable, the insurance contract is between me and my insurance company, therefore, the prompt payment of all fees remains my personal responsibility. I understand that co-payments, annual deductibles, and coinsurance amounts are my responsibility and are due at the time of service.

I understand that all accounts are due and payable, in full, 30 days after my last visit, and will be considered past-due beyond that time. I also understand that I may be charged 18% interest on my account, should the account become more than 90 days past due. I also understand that if my account should be sent to a collection agency, I am responsible for the collection fee charged from that company.

I also authorize Lexington Family Chiropractic to release to my insurance company and/or attorney (either by phone, mail, fax, or email) any information, including diagnosis, records of treatment or examination rendered to me, and account information for all care during the period from ____________________(Today's Date) to the time at which I am released from their care.

___________________________________ ______________________________
Patient/Guardian Signature Date

___________________________________ ______________________________
Staff Signature Date