PATIENT INFORMATION

Name _____ Phone _____

Address _____

Email _____ Sex: M / F Birthdate _____

SS# _____ Primary Care Provider _____

Emergency Contact Person & Phone _____

Have you ever seen a chiropractor or an acupuncturist before? _____

Whom may we thank for referring you? _____

PAYMENT INFORMATION

Payment Type (circle): Insurance Self Pay Medicare Accident Medicaid

Primary Ins: _____ Policy ID# _____ Group# _____

Policy Holder _____ Insured patient is (circle): Self Spouse Child

Policy Holder's Address: _____

Birthdate _____ ID# _____

PATIENT CONDITION

Complaints and symptoms _____

_____

_____

How did this begin?_____

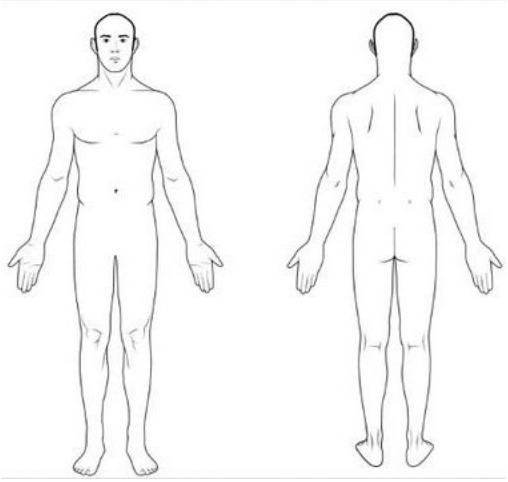
_____

Have you had previous treatment for this complaint?_____

_____

_____

Please mark where your pain is



INFORMED CONSENT, RISKS, RELEASES, & FINANCIAL POLICY

Name: _____ Date: _____

I hereby request and consent to the performance of chiropractic treatment and/or examination by licensed physicians and associated staff of Hillsboro Sports Medicine, P.C., and/or Browning Chiropractic LLC on me or the patient named above who I am legally responsible. Treatment procedures may include spinal manipulation, physical therapeutic modalities, acupuncture, and exercise rehabilitation.

I understand that prior to establishing a treatment plan, the doctor must perform an examination in order to determine the exact cause of the complaint(s). During this examination, the doctor will perform some procedures intended to reproduce the symptoms, which will allow for a better understanding of the nature of my condition. There is a possibility that this exam may temporarily aggravate my symptoms. I also understand that results are not guaranteed. All patient care, including chiropractic care, has the potential for adverse effects.

I understand that the risks associated with chiropractic care include, but are not limited to fractures, disc injuries, strokes, dislocations, and sprains; however, these side effects are extremely rare. The most common side effect following examination and/or treatment is muscle soreness. 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 judgement during the course of treatment and/or procedure, based upon the facts known to him.

I understand that both Hillsboro Sports Medicine, P.C. and Browning Chiropractic LLC file insurance claims as a courtesy to its patients. This does not guarantee coverage or payment for services rendered. The staff will do its best to determine my insurance benefits, but this is only a quote, not a guarantee, provided by my insurance provider. I agree that ultimately all charges incurred at this office are my responsibility and I agree to pay all fees. I hereby assign all insurance benefits, if any, to the treating provider(s).

I authorize the above provider(s) to release any healthcare information they deem necessary to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me in this office.

I have read, or have had read to me, the above consent. I have had the opportunity to ask any questions regarding its content and by signing below, I agree to the above-named procedures. I intend for this consent form to cover the entire course of treatment for my present and any future condition for which I seek treatment.

PATIENT SIGNATURE_____ DATE_____

GUARDIAN SIGNATURE_____ DATE_____

MEDICAL HISTORY FORM

Name_____ Birthdate_____

Height _____ Weight _____ Last Known BLOOD PRESSURE _____

Conditions / Diseases under medical care for: _____

_____

_____

Current Medications:

Medication	Dosage	Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Drug Allergies (list type of reaction) _____

_____

Other Allergies _____

Past Surgeries / Hospitalizations / Major Accidents or Injuries (fractures etc…)

Incident	Year	Incident	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current smoking status (circle one): Smoker (cigarettes per day) _____

Quit / Never Smoked

Are you HIV Positive? Yes / No Have you ever been positive for Hepatitis? Yes / No

By signing below I verify that all the above information is true and accurate.

Signature _____ 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 healthcare 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 before signing this consent.

1. The patient understands and agrees to allow this 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 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 the 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 obligated one time for all subsequent care given the patient in this office.
4. The patient may provide written request to revoke consent at any time during care. This would not effect 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 have 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 doctor or therapist 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.

Signature of Patient Date

Name of Patient

This PHI Consent will be part of your medical record at this facility.