Bryant Chiropractic Clinic

Patient Information

(Please Print in BLACK INK only) • (Please Do Not Leave Any Spaces Blank)

Date: ____/____/____

Personal Information

Name (F) _____ (M) _____ (L) _____

Mailing Address _____ City/State _____ Zip _____

Home Phone _____ Cell Phone _____ Text or Voice Reminder (CIRCLE ONE)

Birthdate _____ Age _____ Gender (circle one) M F Marital Status (circle one) S M W

SSN# _____ Your Email _____

Spouse's Name _____ Spouse's Contact Phone (for emergencies) _____

Spouse's Birthdate _____ Spouse's SSN# _____

Emergency Contact _____ Relationship _____

Your Employer _____ Work Phone _____ Occupation _____

How were you referred? (circle one) yellow pages, another patient, attorney, doctor, sign, other _____

Have you ever had chiropractic care? (circle one) Yes / No If Yes, when? _____

Have you had X-Rays, MRI, or CT Scan of your spine in the past two years? (circle one) Yes / No If yes, where? _____

General Physician _____ General Physician's Phone _____

I hereby authorize and direct you, Bryant Chiropractic Clinic, to release my examination notes to my general physician for his/her use only.

Signature _____

Your Symptoms

A. List your chief complaint(s) on each line (up to four) in order of severity: (examples: headaches, neck pain, back pain, arm pain, leg pain)

1. _____ When and Why did it start? _____
2. _____ When and Why did it start? _____
3. _____ When and Why did it start? _____
4. _____ When and Why did it start? _____

Comments _____

B. (Examples: ice, heat, Advil, Aleve, etc.) (Examples: sitting, bending, lifting, sleeping, turning, etc.)

1. What makes it better? _____ Worse? _____
2. What makes it better? _____ Worse? _____
3. What makes it better? _____ Worse? _____
4. What makes it better? _____ Worse? _____

Comments _____

C. (Circle One)

1. Is the pain? Constant Intermittent How long does it last? _____
2. Is the pain? Constant Intermittent How long does it last? _____
3. Is the pain? Constant Intermittent How long does it last? _____
4. Is the pain? Constant Intermittent How long does it last? _____

Comments _____

D.

1. Does the pain radiate down your arm or leg? (no, yes / explain) _____
2. Does the pain radiate down your arm or leg? (no, yes / explain) _____
3. Does the pain radiate down your arm or leg? (no, yes / explain) _____
4. Does the pain radiate down your arm or leg? (no, yes / explain) _____

Comments _____

E. (Please use a number from 0-10 or a combination of numbers, example: 1-5)

1. How severe is the pain? (0-no pain 10-severe pain) _____
2. How severe is the pain? (0-no pain 10-severe pain) _____
3. How severe is the pain? (0-no pain 10-severe pain) _____
4. How severe is the pain? (0-no pain 10-severe pain) _____

Comments _____

F. (Circle one)

1. Is the pain? Sharp Dull Other _____
2. Is the pain? Sharp Dull Other _____
3. Is the pain? Sharp Dull Other _____
4. Is the pain? Sharp Dull Other _____

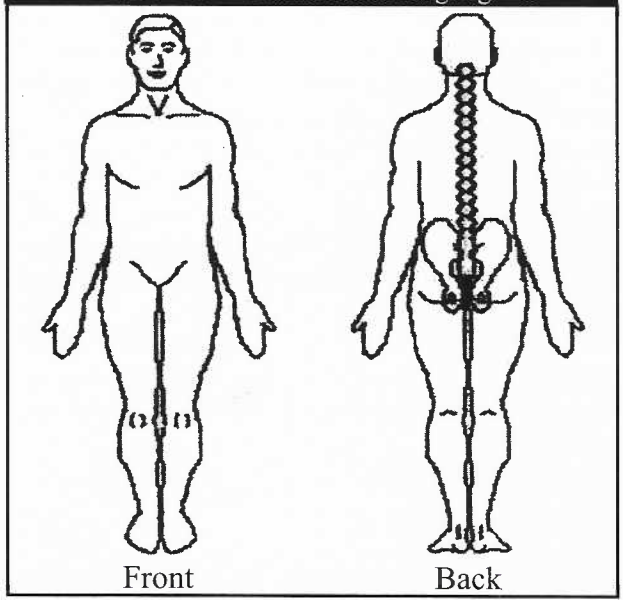
Comments _____

G.

1. Have you ever had similar symptoms? (yes / no) _____
2. Have you ever had similar symptoms? (yes / no) _____
3. Have you ever had similar symptoms? (yes / no) _____
4. Have you ever had similar symptoms? (yes / no) _____

Comments _____

Mark your Area(s) of symptom(s)
Pain = X Numbness or Tingling = O



PLEASE COMPLETE THE REVERSE SIDE

H. How has this condition(s) affected your:

1. Home Life_____
2. Occupational life?_____
   Duties Include: Sittings/hrs_____ Standing/hrs_____ Bending/hrs_____ Lifting/hrs_____ Working at a computer/hrs_____
3. Recreational life?_____
4. Rest and sleep life?_____

Medical History

Surgeries in the past five years:_____

Medication now taking: (include over the counter meds)_____

Cancer:_____

HIV positive? (circle one) Yes No If yes, how long?_____

Family history of (circle which applies) heart disease, diabetes, cancer, other: _____

Other concerns: _____

Work Accident - Are you being evaluated today for a work accident? _____Yes _____No (If yes, please fill out the following)

Date of Accident_____/_____/_____ Did you report this injury to your employer? Yes_____ No_____

Describe your accident_____

_____

Employer Name_____Address_____

Manager's Name_____Phone_____

Workers Compensation carrier_____Phone_____

How many days of work have you lost/ (give dates)_____

Automobile Accident - Are you being evaluated today for an automobile accident? _____Yes _____No (If yes, please fill out the following)

Date of Accident_____/_____/_____ Were you issued a traffic citation? Yes_____ No_____ Police Report? Yes_____ No_____

Describe your accident in detail:_____

_____

Your vehicle was a_____The other vehicle was a_____

How was your vehicle struck? (circle one) Front Rear R-side L-side R-Front corner L-Front corner R-Rear corner L-Rear corner

Your position in the car (circle one) Driver Passenger Front seat Rear seat Did you see the accident coming Yes_____ No_____

Were the brakes applied at the time of the accident (circle one) Yes No

Were you wearing your seat belt? (circle one) Yes No Did your airbag deploy? Yes No

How did you feel after the accident?_____Best describe discomfort during day?_____

Did you sustain any bruises or cuts? (explain)_____

Did you go to the hospital after the accident? Yes No How did you get there? (circle one) Ambulance Drove myself Someone drove me

Name of hospital_____

Treatment received since accident? Yes No Doctor"s name_____

Have you lost any days of work since accident? (give dates)_____

Do you have an attorney? Yes No Attorney's name_____

Attorney's Address_____

Insurance company responsibe_____

Your car insurance_____Med Pay Claim#_____

Adjuster's Name_____Adjuster's Phone #_____

Assignment, Lien, Authorization for Insurance Benefits, and Power of Attorney

I hereby authorize and direct you, my insurance company and/or my attorney to pay directly to Bryant Chiropractic Clinic, 1600 Sparkman Drive, Huntsville, AL 35816, such sums as may be due and owing this office for services rendered to me, both by reason of accident or illness and by reason of any bills that are due this office and to withhold such sums from any disability benefits, workers compensation benefit, no-fault benefit, health and accident benefit or any other benefit obligated to reimburse me or from any settlement, judment, or verdict on my behalf as may be necessary to adequately protect said office. I understand that I remain personally responsible for the grand total amounts due to the office for services rendered. I understand that if I decide to change chiropractors before my personal injury case is settled I will be required to pay all sums due within seven working days from the day I change providers. I further understand and hereby grant to Bryant Chiropractic Clinic Power of Attorney for the sole purpose of endorsing on my behalf any negotiable instrument payable to this clinic for services rendered by them. I authorize Bryant Chiropractic Clinic to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this assignment, lien, and authorization.

I agree to pay for any attorney or collection agency fees incurred as a result of my failure to pay amounts due in a timely manner. If this account is turned over to an attorney for collection, I agree to pay all costs of collection including a reasonable attorney's fee for his reasonable percentage charged for the collection process. I hereby state that a photocopy of this document will be deemed as valid and binding on all parties as the original copy.

Patient Signature_____BCC Employee Signature_____Date_____/_____/_____

THANK YOU FOR YOUR REFERRALS

Bryant Chiropractic Clinic

Bryant Chiropractic Clinic LLC
1600 Sparkman Dr NW
Huntsville, AL 35816
p 256.837.8111
f 256.837.6200
bryantchiroclinic.medicfusion.com

Patient: _____

AUTHORIZATIONS AND RELEASES

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.

Initials: _____

Consent to Perform and Interpret X-rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

Initials: _____

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. For more information about Health Information Portability and Accountability Act (HIPAA) and health information privacy visit: hhs.gov - Understanding Health Information Privacy

- The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.

- The patient has the right to examine and obtain a copy of their 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. This office is not obligated to agree to those restrictions.

- The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.

- This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.

- Patients have the right to file a formal complaint with our privacy official about any suspected violations.

- This office has the right to refuse treatment if the patient does not accept the terms of this policy.

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Financial Obligation and Appointment Policy

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.

Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

You may direct any questions regarding this financial obligation to the clinic manager or physician.

Initials: _____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor and certified staff have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to a fetus.

Initials: _____

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

Initials: _____

Insurance / Medicare payment-Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct.

I authorize this office and/or doctor to act as my agent in helping me obtain payment of my insurance and/ or Medicare benefits, and I authorize payment of these benefits to this clinic and/or doctor of record on my behalf for any services and materials furnished.

Initials: _____

Consent to Chiropractic Treatment

Please read this entire section regarding chiropractic care prior to accepting it. It is important that you understand the information contained in this section. Please ask questions before you accept it if there is anything that is unclear. You are the decision maker for your health care. Part of the role of this clinic is to provide you with information to assist you in making informed choices. This process is often referred to as 'informed consent' and involves your understanding and agreement regarding the care that this clinic recommends, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. The nature of the chiropractic analysis and treatment The primary treatment that is performed by a Doctor of Chiropractic is spinal manipulative therapy. This clinic may use that procedure to treat you. This may include the use of the hands or a mechanical instrument upon your body in such a way as restore normal joint motion. It may cause an audible 'pop' or 'click,' much as you have experienced when you 'crack' your knuckles. You may feel a sense of movement. Analysis/ Examination / Treatment As a part of the analysis, examination, and treatment, the doctor may want to employ a variety of procedures as may be deemed necessary. These procedures include but are not limited to: Spinal manipulative therapy, chiropractic adjustments, vital signs, range of motion

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testing, palpation, orthopedic testing, basic neurological testing, postural analysis testing, muscle strength testing, radiographic studies, scanning of feet, EMS, exercises, acupuncture, myofascial treatments, hot/cold therapy, mechanical traction, traction/decompression, laser therapy, vibrational pivot platform, or cranial balloon adjustments (CFR). By accepting this document you are consenting to these procedures as recommended/prescribed by this clinic. The material risks inherent in chiropractic adjustment. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation or from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an 'arterial dissection' that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which the provider will check during the taking of your history during examination and X-ray. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admissions attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons and the risk of death has been estimated at 140 per one million users. The availability and nature of other treatment options. Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted other treatment options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. The risks and dangers to remaining untreated. Remaining untreated may allow the formulation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed with the clinic any questions and concerns I have and they have been answered to my satisfaction. By accepting, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Initials: _____

Females: Consent to X-Ray During Pregnancy

This is to certify that, I am or may be pregnant and that the doctor or certified staff has my permission to perform diagnostic x-rays involving any cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be used over the trunk of my body. I have been advised that certain x-rays, particularly those involving the pelvis, can be hazardous to a fetus.

Initials: _____

Signature: _____ Date: _____