Confidential Patient Information

Last Name: ________________________ First Name: ____________________ Middle: ___________________ Sex: ☐F ☐M

Date of Birth:______________ Social Security #: _____________________ Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Other:

Address: ____________________________________ City: ___________________ State: ____________ Zip:_________________

Home Phone: __________________________ Work Phone: ______________________ Cell Phone:________________________

Preferred Phone: ☐Home ☐Work ☐Cell

Email:____ Is this visit related to: ☐Auto Accident ☐Work Accident ☐Other Accident

Name of Spouse or Nearest Relative: ____ Phone: __________________________

Referred to this office by: ____

Payment Agreement and Financial Policy

We are committed to providing our patients with the best possible care and minimize administrative costs. This Financial Policy has been established with these objectives in mind, and to avoid any misunderstanding or disagreement concerning payment for professional services.

Payment for services will be by (Check all that apply): ☐ Cash ☐Check ☐Master Card or Visa

Our office does not participate with insurance companies and managed health care programs. **We do, however, process claims for Medicare, Auto, Worker's Comp. and health insurance companies with OUT OF NETWORK chiropractic care benefits**. Please provide a copy of your insurance card and complete all necessary insurance information, including special forms, before leaving the office. It is your responsibility to provide us with current insurance coverage information and all required personal data.

Patients that do not have insurance coverage for Chiropractic Care are expected to pay for professional services at time of service unless prior arrangements have been made with us.

Would you like our office to file with your insurance company? ☐YES (If yes, complete section below) ☐NO

What type of insurance coverage will you be using? (Check one!)

☐Health Insurance ☐ Medicare ☐ Automobile Insurance ☐Worker's Compensation

Insurance Company: ____ Insured's Employer:__________________

Insured's Social Security # (if different from above):

Are you covered by more than one insurance company (not including Medicare)? ☐YES ☐NO Name: ___________________________

- There is no guarantee that your insurance company will pay for all services rendered. If we have not received payment within sixty days we will notify you and unpaid balances will become your responsibility, and we will expect payment in full at that time.
- It is the patient's responsibility to pay any deductible or any portion of the charges as specified by the plan at the time of visit.
- It is the patient's responsibility to ensure that any required referrals for treatment are obtained **before the visit** or the patient may be financially responsible due to lack of the referral at time of service.
- The parents/guardians of a minor are responsible for payment incurred by the minor.
- Any medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit.
- We are happy to help with insurance questions relating to how a claim was filed, however, specific coverage issues, can only be addressed by the insurance company's member services department (number is on the insurance card).

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and good communication. Questions about financial arrangements may be directed to the physician's office at any time. Please do not hesitate to contact us. We are here to help you!

Cancellation Policy

- **Patient will be responsible for paying a $30 cancellation fee for any missed/cancelled appointment of less than 12 hours notice.**

Assignment And Release

I, the undersigned certify that I (or my dependent) have insurance coverage with______________And assign directly to __________ all insurance benefits, if any. I am responsible for paying a $30.00 fee for any missed or cancelled appointments without a 24-hour notice. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

________________________________ ____

Date **Signature**

Purpose of Appointment:____
When did it start?____
(Include month and year, day if known)

What makes the pain worse? ____
What makes the pain better?____

How would you describe your pain?_____________________________________

Height: _______ Weight (current)______ One Yr. Ago: _______

Adult Max:______ Age:____ Adult Min:_______ Age:____Blood Type:______

Have You Ever Had A Blood or Plasma Transfusion? Y / N
Date of Last Physical Exam:____
With whom: _______________________Where: _______________________
Reported Findings: ____
____
At what time of the day or week is your pain worse?______________________
The pain is: ______ Intermittent _____ Constant ______
Have you had this problem in the past? _____ If so, how often? _____________
Other Doctors Seen For This Condition:_______________________________
Any medical diagnoses of your complaint?______________________________
Have you ever received any treatment for this condition? If yes, when, where, and what were the results?____
Have you ever been treated by a chiropractor before? Y / N Results? _______
____

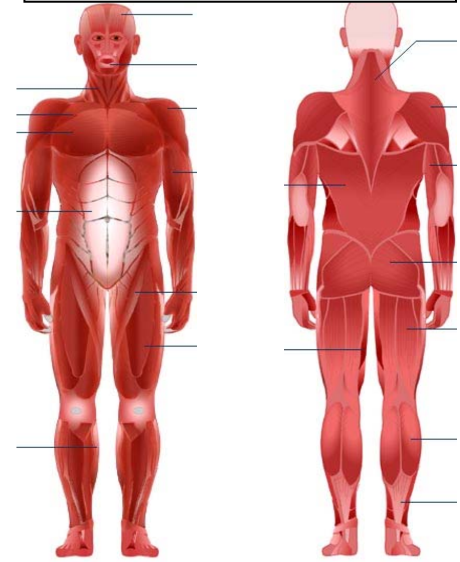
Is your pain the result of a motor vehicle accident? Y / N

Have you filed a legal suit? Y/N

Is your pain the result of a work related injury? Y/N

If so, have you filed a worker's compensation claim? Y/N

(1) INDICATE AREA(S) OF CONCERN



(2) INDICATE INTENSITY OF PAIN

Please list hospitalizations, surgeries, accidents, fractures, dislocations, major dental work you have had.

____Date or Age___________
____ __ Date or Age___________
____Date or Age___________
____Date or Age____________
____Date or Age____________
____Date or Age____________

XRAY HISTORY: (Include MRI,CT, CAT, Doppler and Dental) When was most recent x-ray/other study?________________________________

Age	Body Area	Type (normal X-ray, CAT, MRI, ect.)	No. of Studies

WOMEN ONLY: Menstrual History
Age at Onset:___________ Are your Periods Regular? Y / N
Cycle:_________ days (start to finish) Use Birth Control Pill? Y / N
Your Flow Is: Heavy Medium Light Date of Last Period:____________
Are You Pregnant? Y / N How Many Months:_________
Cramping? Y / N PMS? Y / N
Do you experience other Menstrual / Hormonal Symptoms:____
Vaginal Infections? Y / N Miscarriage? Y / N

What medications, vitamins, supplements, herbs do you take?

Name	Reason
______________________________________ __	____
____	____
____	____
____	____
____	____

Known Allergies: ____

Conditions You or a Family member has had: (Y for you, F for Family Member or B for Both)

___ AIDS/HIV
___Alcoholism
___Allergies
___Anemia
___Anorexia
___Arthritis/Joint Pain
___Asthma
___Backaches
___Bleeding Disorders
___Breathing Problems
___Bulimia
___Cancer
___Depression
___Diabetes
___Digestive Disorders
___Dizziness
___Epilepsy
___Fatigue
___Gout
___Headaches
___Heart Trouble
___ Hepatitis
___ Hernia
___Herniated Disk
___High Blood Pressure
___ High Cholesterol
___ Hypoglycemia
___ Neck Pain
___Nervousness
___Neuritis
___ Numbness
___Osteoporosis
___ Pacemaker
___ Parasites
___Pinched Nerve
___ Poor Circulation
___ Prostate Problem
___ Prosthesis
___ Rheumatic Fev
___ Sinus Troubles
___ Stroke
___ Tuberculosis
___Ulcers
___Urinary Trouble
___Venereal Disease
___Weight Loss
___ Yeast/ Candida

Any other concerns you'd like to share?____

How many times a week do you engage in physical activity that is sufficiently prolonged and intense to cause sweating and raise your heart rate?____

When you engage in the physical activity noted above, what is the average duration of activity?
____ Less than 10 minutes ____ 10-20 minutes ____ 20-30 minutes ____ 30-60 minutes ____over 60 minutes
When you engage in the physical activity noted above, what do you feel the level of effort is?_______________________________
At work, how many days per week do you engage in tasks that are intense enough to cause sweating and a rapid hear rate?____

Habits:

Do you Smoke? Y / N What?___________________________ How Many / Day:_______________________ Since When?__________

Other Tobacco Products? Y / N What?_____________________ How Many / Day:_______________________ Since When? __________

Drink Coffee? Y / N Cups / Day?_____________________ Drink Caffeinated Tea? Y/ N Cups / Day? ___________

Colas / Soft Drinks? Y / N Number / Day?________________________ Glasses of Water / Day?___________________________

Alcoholic Beverages? Y / N Avg. No. / Wk?________________________ Mostly What?___________________________

Do You Eat Red Meat? Y / N Are You A Vegetarian? Y / N If So, For How Long:__________________________

Are You Dieting Y / N If So, Describe:____

Do You Eat in Fast Food Restaurants? Y / N If So, How Many Times / Week?____

List Nutritional Supplements You Take:____

Bowel Movement Frequency:__________________________ Difficulty? Y / N Approximate # of Times You Urinate / Day:____________

Do You Sleep Well? Y / N If No, Describe:____ Average Hours / Night:____________

Do You Have Sufficient Energy For Normal Activities? Y / N If No, Describe:____

Do You Wear Corrective Lenses? Y / N What Is Your Uncorrected Vision? Right:_____/20 Left:_____/20

Has Your Vision Changed Recently? Y / N Do You Wear Heel Lifts or Foot Supports? Y /N

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NOTICE OF PRIVACY PRACTICES

The Hippa Privacy Rule enacted by the US Congress states patients' right to, and reinforces the protection of their medical records, or Protected Health Information (PHI). This means that you, the patient, have right to the access and the privacy of your PHI. This also means that your physician must obtain your consent/authorization *to use* your PHI by the physician himself and his office employee/business associates, and *to share* the appropriate PHI with your pharmacies, referral, physicians, health-related facilities, laboratories, and your health insurance, in order to conduct the usual medical care and obtain service reimbursement. The entire Privacy Rule is available at the reception desk.

HIPPA ACKNOWLEDGEMENT & AUTHORIZATION

Request for Services and Release of Records to Patients. I acknowledge and agree that I have personally requested health Care from *Dr. Melanie L. Six, DC and/or any other physician or health care practitioner in the employment of and at the office of Dr. Melanie L. Six, DC located at 3335 Duke Street, Alexandria, VA 22314.* I understand that I can receive, at each visit, a copy of my medical record for the visit. I agree to keep each document of my medical records for my future use. I understand that I can obtain another copy of my medical records in the future at a usual and customary fee for making such a copy.

Authorization for Use or Disclosure of PHI. I authorize *employees and business associates of Dr. Melanie L. Six, DC* to use and release my PHI for the purpose of usual and customary medical cares for myself and billing my health insurance, I understand that I have the right to revoke this authorization by sending my written request to *Dr. Melanie L. Six, DC at 3335 Duke Street, Alexandria, VA 22314*. I understand that my authorization is voluntary and that I may refuse to sign this authorization. But by not giving such authorization, *I also understand that* Dr. Melanie L. Six, DC *my be limited in her ability to provide services to me* since the exchange of PHI is necessary in such activities as, but not limited to ordering tests, prescriptions, referrals, and billings to insurance. *If I choose not to sign the authorization, I also assume all financial responsibility for any services rendered at the time of service, and incurred at other medical facilities.*

______________________________	______________________________	____________
Signature of Patient/Personal Representative	Print name of Patient	Date