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!

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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 and 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. I also acknowledge I am responsible for paying a $50.00 fee for any missed or cancelled appointments without a 12-hour notice

_____ _____

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? _____
_____

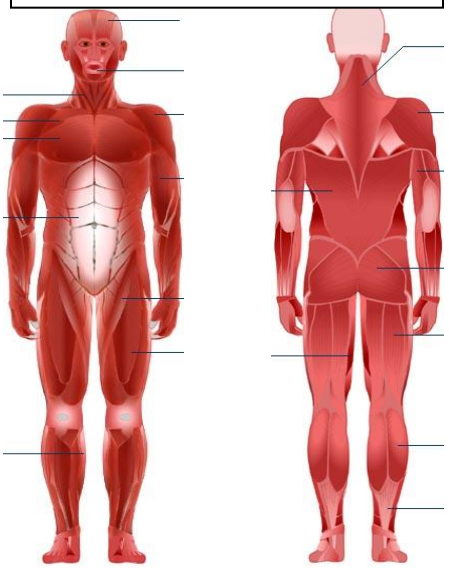
Is your pain the result of a motor vehicle accident? Y / N

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

0 1 2 3 4 5 6 7 8 9 10
No Pain Excruciatin

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 (Y for You), family members (F for Family) or Both (B for Both) has had:

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

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?_____

How many days per week do you engage in tasks that are intense enough to cause sweating and an increase heart 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 2121 Eisenhower Ave. Ste. 101 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 2121 Eisenhower Ave. Ste. 101 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 *maybe 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

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy, and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The Chiropractic adjustment and other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VCS. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy.
I have read, and understanding the forgoing.

_____ _____

Signature **Date**